

# Samaritan Risk Retention Group

*A Baptist Health South Florida-sponsored Program*

## *Application for* **Claims-Made** **MEDICAL PROFESSIONAL LIABILITY INSURANCE**

### **Checklist:**

Please include copies of the following along with your application:

- \_\_\_\_\_ 1. C.V.
- \_\_\_\_\_ 2. Medical and DEA Licenses
- \_\_\_\_\_ 3. Board Certification
- \_\_\_\_\_ 4. Declarations Page from expiring insurance policy (*including expiring premium*)
- \_\_\_\_\_ 5. Practice Letterhead
- \_\_\_\_\_ 6. Loss History Reports from prior carriers (*past 10 years*)

### **RETURN APPLICATION TO:**

Aon Risk Services, Inc. of Florida  
Attention: Carlota Redondo  
1001 Brickell Bay Drive, Suite 1100  
Miami, FL 33131  
Toll Free Telephone: (800) 743-3486 / (305)-961-6125  
Fax: (305) 372-1455

#### **NOTICE:**

**The policy for which you are applying is issued by a risk retention group. The 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.**



BAPTIST HOSPITAL OF MIAMI • SOUTH MIAMI HOSPITAL • DOCTORS HOSPITAL  
BAPTIST CHILDREN'S HOSPITAL • HOMESTEAD HOSPITAL • MARINERS HOSPITAL  
BAPTIST OUTPATIENT SERVICES • BAPTIST CARDIAC & VASCULAR INSTITUTE

# Samaritan Risk Retention Group

*A Baptist Health South Florida-sponsored Program*

Application for Individual Medical professional liability insurance. A claims-made policy covers claims arising from the performance of professional services after the retroactive date shown on the policy and first brought against you while the policy is in effect. Please type or print in blue or black ink. All questions must be answered completely. If a question does not apply to you or your practice, please indicate by writing "no", "none", or "N/A" (non-applicable).

## COVERAGE REQUESTED

1. Effective date of coverage requested (If approved, earliest date coverage can begin is 12:01 a.m., the day following receipt of completed application): \_\_\_\_\_  
Month / Day / Year

2. Retroactive date requested (If applying for Prior Acts Coverage): \_\_\_\_\_  
Month / Day / Year

3. Specialty for which this coverage would apply: \_\_\_\_\_  
(e.g. Family Practice, OB/GYN Surgery)

4. Limits of Liability requested (limits indicated are per medical incident/annual aggregate):  \$250,000 / \$750,000  
 "I understand that if approved for coverage, my limits of liability will be \$250,000/\$750,000 regardless of the limit I formerly carried with my previous insurance carriers."  
 Initial here that **you understand and accept these conditions:**  \_\_\_\_\_

## APPLICANT INFORMATION

5. **APPLICANT NAME:**

\_\_\_\_\_

Last Name First Name Middle Initial Degree

6. a.) Date of Birth: \_\_\_\_\_ b.) Gender: \_\_\_\_\_ c.) Social Security #: \_\_\_\_\_

7. a.) Medical License: State: \_\_\_\_\_ License #: \_\_\_\_\_ Active / Inactive  
 State: \_\_\_\_\_ License #: \_\_\_\_\_ Active / Inactive

8. Office Locations *(Principal Location First; list additional practice locations on Supplemental Page):*

#1 \_\_\_\_\_ Telephone: \_\_\_\_\_  
Street Suite  
 \_\_\_\_\_ Facsimile: \_\_\_\_\_  
City State Zip Code County

#2 \_\_\_\_\_ Telephone: \_\_\_\_\_  
Street Suite  
 \_\_\_\_\_ Facsimile: \_\_\_\_\_  
City State Zip Code County

9. Residential Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Street Apt #  
 \_\_\_\_\_ Facsimile: \_\_\_\_\_  
City State Zip Code County

Preferred Mailing Address:  Office  Home

10. a.) List all hospitals, nursing homes or outpatient facilities where you are or will be on staff, have privileges or render professional medical services, including managed care organizations. *(List others on Supplemental Page)*

Name	Address, City, State	Status of Privileges (Active, Temp., Courtesy)	Practice %	Send Certificate?	
				Y <input type="checkbox"/>	N <input type="checkbox"/>
				Y <input type="checkbox"/>	N <input type="checkbox"/>
				Y <input type="checkbox"/>	N <input type="checkbox"/>
				Y <input type="checkbox"/>	N <input type="checkbox"/>

# PERSONAL, HOSPITAL AND LICENSE INFORMATION

<b>11.</b>	Are you now, or have you ever been, evaluated, treated or hospitalized for the use of any of the following: (Please explain on supplemental page.)	<b>YES</b>	<b>NO</b>
	a) Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
	b) Narcotics	<input type="checkbox"/>	<input type="checkbox"/>
	c) CNS stimulants or depressants	<input type="checkbox"/>	<input type="checkbox"/>
<b>12.</b>	Are you now, or have you ever been, evaluated, treated or hospitalized for any mental or emotional disorders? (Please explain on supplemental page.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>13.</b>	Have you ever incurred or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? (e.g. alcoholism, convulsive disorders) If YES, did you submit your treating physician statement to the hospital for review? (Please explain on supplemental page.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>14.</b>	Have you ever been charged with, convicted or found guilty (even if adjudication withheld) of violating any federal, state law or municipal ordinance (other than traffic offenses or minor offenses involving a fine of \$100.00 or less)? (Please explain on supplemental page.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>15.</b>	Has your application for medical staff privileges at a hospital, other health care facility or managed care organization, ever been denied or restricted? (Please explain on supplemental page.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>16.</b>	Have your medical staff privileges ever been revoked, suspended or restricted? (Please explain on supplemental page.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>17.</b>	Has your membership in a medical society or professional organization ever been denied, suspended, revoked, or subjected to disciplinary proceedings due to professional or ethical conduct? (Please explain on supplemental page.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>18.</b>	Have you ever received any of the following: (Please explain on supplemental page.)		
	a) Any hospital disciplinary action due to professional and/or behavioral reasons?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Licensing board disciplinary or administrative proceeding due to impropriety or incompetence in a medical practice?	<input type="checkbox"/>	<input type="checkbox"/>
	c) Licensing board disciplinary or administrative proceeding due to prescribing, dispensing, or distributing pharmaceuticals?	<input type="checkbox"/>	<input type="checkbox"/>
<b>19.</b>	Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered or subject to probationary terms (in any jurisdiction)? (Please explain on supplemental page.)		
	a) Medical License	<input type="checkbox"/>	<input type="checkbox"/>
	b) DEA License	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE: If any of the questions are answered YES, a detailed explanation, in writing, MUST accompany application. Questions 11 through 13 require a letter from the attending physician or institution outlining the diagnosis, dates of treatment and current status. Questions 14 through 19 require a copy of all legal documents (e.g. Complaint, Stipulation, Final Order, Resolution).**

## MEDICAL EDUCATION

**20. Medical School:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**Internship:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**Residency:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Specialty: \_\_\_\_\_ Completed?: Y  N

**Fellowship Type:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Specialty: \_\_\_\_\_ Completed?: Y  N

Explain any gaps in time from date of medical school graduation to completion of training: \_\_\_\_\_

## SPECIALTY BOARD CERTIFICATIONS

<p><b>21.</b> Indicate if you are certified by the <b>American Board of Medical Specialties, Advisory Board for Osteopathic Specialists or American Podiatric Medical Association</b></p> <p>If Yes, name of Board: _____ Date Certified: _____</p>	<p><b>YES</b></p> <p><input type="checkbox"/></p>	<p><b>NO</b></p> <p><input type="checkbox"/></p>
<p><b>22.</b> If you are NOT certified:</p> <p>a) Are you board eligible? If YES: Date of eligibility: _____ Anticipated exam date: _____</p> <p>b) Have you been an applicant or candidate for over five years? If YES, please explain: _____ _____</p> <p>c) Have you ever failed the written exam? If YES, please indicate the number of times: _____</p> <p>d) Have you ever failed the oral exam? If YES, please indicate the number of times: _____</p> <p>e) Have you ever been denied certification by a specialty board? If YES, please explain: _____</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>

## PROFESSIONAL LIABILITY INSURANCE COVERAGE

<p><b>23. a.)</b> List all professional liability insurance carried during the last ten years (use additional page if necessary):</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #cccccc;"> <th style="width: 20%;">Name of Carrier</th> <th style="width: 15%;">Policy Number</th> <th style="width: 15%;">Policy Effective</th> <th style="width: 15%;">Policy Expiration</th> <th style="width: 15%;">Specialty Covered</th> <th style="width: 15%;">Policy Limits</th> <th style="width: 10%;">“Tail” Purchased?</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>b.) Have you ever failed to maintain continuous professional liability insurance while rendering professional services? (If YES, please attach explanation.)</p>	Name of Carrier	Policy Number	Policy Effective	Policy Expiration	Specialty Covered	Policy Limits	“Tail” Purchased?																																				<p><b>YES</b></p> <p><input type="checkbox"/></p>	<p><b>NO</b></p> <p><input type="checkbox"/></p>
Name of Carrier	Policy Number	Policy Effective	Policy Expiration	Specialty Covered	Policy Limits	“Tail” Purchased?																																						

## PRIOR ACTS COVERAGE

<p><b>24.</b> Type of current medical professional liability insurance: <input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence</p>		
<p><b>25.</b> If currently insured with a claims-made policy, are you requesting Prior Acts Coverage? (A copy of the current carrier’s Declarations page or certificate of insurance <b>MUST</b> be submitted.)</p> <p>a) If YES, please advise on your current carrier’s claims trigger: <input type="checkbox"/> Incident <input type="checkbox"/> Formal Complaint <input type="checkbox"/> Unknown</p> <p>b) If NOT REQUESTING PRIOR ACTS coverage and you are currently insured with a claims-made policy, are you purchasing an Extended Reporting Endorsement (“tail”) from your current carrier?</p> <p>c) If NOT REQUESTING PRIOR ACTS AND NOT PURCHASING “TAIL”, please review the following statement: “I understand that unless I obtain Prior Acts Coverage or Purchase Tail, I will have <b>NO</b> coverage for any claims which may arise in the future as a result of any act or omission which occurred prior to the effective date of this policy.” Initial here <b>if you are NOT</b> requesting Prior Acts Coverage : <b>X</b> _____</p>	<p><b>YES</b></p> <p><input type="checkbox"/></p> <p><b>YES</b></p> <p><input type="checkbox"/></p>	<p><b>NO</b></p> <p><input type="checkbox"/></p> <p><b>NO</b></p> <p><input type="checkbox"/></p>
<p><b>26.</b> Are you a Medical Director of a nursing home, health care facility or any other business enterprise providing medical services? If YES, do you render patient care in your capacity as Medical Director to all patients at the facility? <b>If you do not render patient care to all patients at the facility, please provide evidence of your coverage for the medical directorship exposure.</b></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>

## CLASSIFICATION INFORMATION

YES NO

<p>27. Has there been a change in your specialty or rating classification during the time period stated above? If YES, please explain. (Use additional page if necessary.)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>28. a.) Hours worked per week: _____ Average # of Patients seen per week: _____</p>		
<p>29. Do you evaluate medical procedures, devices, drugs, drug regimens, therapy or clinical research or perform any procedure in your medical practice that is in an experimental stage or not FDA approved?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>30. a.) Where (locations) have you practiced for the past 10 years or since your retroactive date, whichever is greater? (Use additional page if necessary.) _____ _____ _____ b.) Explain any gaps in time between the locations indicated above: _____ _____</p>		
<p>31. Have you had more than 5 practice relocations?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>32. As of the requested retroactive date for coverage, have you or will you practice Telemedicine, E*Commerce Medicine or practice medicine outside the state in which you have applied for coverage? If YES, please explain below. (Use additional page if necessary.) _____ _____</p>		
<p>33. Does your practice include the following (check all that apply)?</p>		
<input type="checkbox"/> <b>No Surgery</b>	<p>No surgery, with the exception of: suture of minor lacerations; incision of sebaceous boils and cysts; needle aspiration of cysts (limited to subcutaneous tissue); incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.</p>	
<input type="checkbox"/> <b>Minor Surgery</b>	<p>Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures:</p> <ul style="list-style-type: none"> <li>• Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP);</li> <li>• Pneumatic or mechanical esophageal dilation (not with bougie or olive);</li> <li>• Angiography, Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists that completed a cardiovascular subspecialty training);</li> <li>• Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue;</li> <li>• Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae.</li> </ul> <p><b>No general Anesthesia.</b></p>	
<input type="checkbox"/> <b>Major Surgery</b>	<p>Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It includes all operations using general anesthesia.</p>	
<input type="checkbox"/> <b>Radiology (Diagnostic)</b>	<p>Indicate the annual number of readings performed: _____ Type of readings performed: _____</p>	
<input type="checkbox"/> <b>Elective Plastic Surgery</b>	<p>Non-Plastic Surgeons, please indicated the following: Types of procedures performed: _____ Annual number performed: _____ Training received to perform procedures: _____</p>	
<input type="checkbox"/> <b>Bariatric Surgery</b>	<p>Supplemental application will need to be completed.</p>	

## CLASSIFICATION INFORMATION (con't.)

34. Please check any of the following procedures you will perform:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abortions<br><input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester                                      | <input type="checkbox"/> Laparoscopy   | <input type="checkbox"/> Pacemakers under General Anesthesia   |
| <input type="checkbox"/> Acupuncture  | <input type="checkbox"/> Laser Surgery   | <input type="checkbox"/> Phenol Facial Peels   |
| <input type="checkbox"/> Therapeutic/Local Anesthesia   | <input type="checkbox"/> Laser Therapy (Endoscopic)  | <input type="checkbox"/> Polypectomy   |
| <input type="checkbox"/> General Anesthetic   | <input type="checkbox"/> Liposuction   | <input type="checkbox"/> Silicone Injections   |
| <input type="checkbox"/> Angiography  | <input type="checkbox"/> Lymphangiography  | <input type="checkbox"/> Skin Flap/Grafts<br>Cosmetic____% of practice<br>Reconstruction____% of practice  |
| <input type="checkbox"/> Angioplasty  | <input type="checkbox"/> Lithotripsy   | <input type="checkbox"/> Swan-Ganz Catheterization   |
| <input type="checkbox"/> Arthroscopy  | <input type="checkbox"/> Major Gynecological Surgery   | <input type="checkbox"/> Left Heart Catheterization  |
| <input type="checkbox"/> Arteriography  | <input type="checkbox"/> Mammography   | <input type="checkbox"/> Right Heart Catheterization (other than CVP Lines)  |
| <input type="checkbox"/> Assisting in major surgery<br><input type="checkbox"/> Own patients only<br><input type="checkbox"/> Own and other than own patients | <input type="checkbox"/> Myelography   | <input type="checkbox"/> Tubal Ligations   |
| <input type="checkbox"/> Biopsy (Endoscopic)  | <input type="checkbox"/> Needle Biopsy   | <input type="checkbox"/> Vasectomies   |
| <input type="checkbox"/> Blepharopigmentation   | <input type="checkbox"/> Nerve blocks<br><input type="checkbox"/> Lumbar Epidural Steroid  | <input type="checkbox"/> Weight Control Therapy/Surgery<br><input type="checkbox"/> ___ % practice   |
| <input type="checkbox"/> Blepharoplasty – Brow Lifts<br>Cosmetic____% of practice<br>Reconstruction____% of practice  | <input type="checkbox"/> Paraspinal <input type="checkbox"/> Sciatic   | <input type="checkbox"/> Medication-Weight Control   |
| <input type="checkbox"/> Breast Implants<br>Cosmetic____% of practice<br>Reconstruction____% of practice  | <input type="checkbox"/> Facet <input type="checkbox"/> Paravertebral  | <input type="checkbox"/> Gastric Bubble / Stapling   |
| <input type="checkbox"/> Bronchoscopy   | <input type="checkbox"/> Peripheral <input type="checkbox"/> Myofascial  | <input type="checkbox"/> Other Weight procedures   |
| <input type="checkbox"/> Cataract Surgery   | <input type="checkbox"/> Occipital <input type="checkbox"/> Trigger Point  | <input type="checkbox"/> Prenatal Practice<br><input type="checkbox"/> See patients during First and Second Trimester<br><input type="checkbox"/> See patients to Term but do not Perform Delivery<br><input type="checkbox"/> See patients to Term and Perform Delivery |
| <input type="checkbox"/> Colonoscopy  | <input type="checkbox"/> Percutaneous Vertebroplasty   | <input type="checkbox"/> Normal Obstetrical Deliveries<br>How many per year?_____  |
| <input type="checkbox"/> C-T Scans (Computerized Tomography)  | <input type="checkbox"/> Nerve blocks  | <input type="checkbox"/> Cesarean Sections<br>How many per year?_____  |
| <input type="checkbox"/> Cryosurgery (other than external lesions)  | <input type="checkbox"/> Phlebography  | <input type="checkbox"/> Home Deliveries<br>How many per year?_____  |
| <input type="checkbox"/> Encephalography  | <input type="checkbox"/> Phneumoencephalography  | <input type="checkbox"/> Other Medical Techniques<br>_____   |
| <input type="checkbox"/> ERCP   | <input type="checkbox"/> Radial/Laser Keratotomy   |  |
| <input type="checkbox"/> D & C  | <input type="checkbox"/> Radiology - Interventional<br><input type="checkbox"/> Needle Biopsy & Injection<br><input type="checkbox"/> IV to the Vein |  |
| <input type="checkbox"/> Diagnostic Embolization  | <input type="checkbox"/> Radiation/X-Ray Therapy   |  |
| <input type="checkbox"/> Flourosocopy   | <input type="checkbox"/> Radiopaque Dye<br><input type="checkbox"/> Non-Ionic Only   |  |
| <input type="checkbox"/> General/Spinal/Caudal Anesthesia<br><input type="checkbox"/> In a non-hospital setting?  | <input type="checkbox"/> Shock Therapy   |  |
| <input type="checkbox"/> Gastrointestinal Endoscopy   | <input type="checkbox"/> Sialography   |  |
| <input type="checkbox"/> Hair Transplants   | <input type="checkbox"/> Sigmoidoscopy<br><input type="checkbox"/> < 60 cm<br><input type="checkbox"/> > 60 cm                                       |  |
|   | <input type="checkbox"/> Perinatology / Neonatology<br><input type="checkbox"/> # of Deliveries: _____   |  |

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

___% Plastic(Reconstruction only)	___% Thoracic	___% Orthopedic (Including back)
___% Plastic(Cosmetic Enhancement)	___% Cardiac	___% Orthopedic (Not including back)
___% Hand	___% Vascular	___% Other _____
___% Traumatic	___% Obstetrics	_____

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 36. Do you attend or supervise deliveries in a non-hospital setting?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do you perform any of the following:  | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Chelation Therapy for other than lead poisoning  | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Home Deliveries  | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Second Trimester Abortions in a non-hospital setting   | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Botox Injections (if other than a plastic surgeon)   | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Bariatric Surgery (please complete supplemental application)   | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Any non-FDA approved procedure/trial.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you changed specialties/procedures in the past five years?<br>If YES, please detail your prior practice on the Supplemental Page.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Do you serve in a hospital emergency room for which you require this policy to provide coverage?<br>If YES, number of hours per month:_____If the ER exposure is covered by another carrier, see next question. | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Will you be performing activities which will be covered by another professional liability policy?<br>If YES, please provide description of activities and certificate of coverage.                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you perform any procedure for which you have not been approved to perform at any Baptist Health South Florida healthcare facility? If YES, please explain. (Use additional page if necessary.)               | <input type="checkbox"/> | <input type="checkbox"/> |

## EMPLOYMENT INFORMATION

42. Are you currently employed with a group that is Insured with Samaritan Risk Retention Group, Inc.  Y  N or are you a contract physician for Baptist Health South Florida?

If "yes", please provide name of your employer and/or copy of your contract/employment agreement with Baptist Health South Florida.

## ENTITY COVERAGE

- 43a. Do you desire coverage for your Professional Entity?  Y  N

If "yes", please provide a copy of your Letterhead and Articles of Incorporation.

- 43b. What type of coverage do you desire for your Professional Entity?

\_\_\_\_\_ Separate Limits (for an additional 30% of the total physician premium)  
(This option is not available for Solo Practitioners)

\_\_\_\_\_ Shared Limits (no additional premium)

Note: Entity coverage will only be provided for physicians/physician extenders that are currently employed by the entity and insured with Samaritan. Entity coverage for physicians/physician extenders that have left the group prior to it joining Samaritan will need to be underwritten separately.

44. Legal Name of Group to be insured: \_\_\_\_\_

Type: \_\_\_\_\_ Solo Practitioner \_\_\_\_\_ Partnership \_\_\_\_\_ Medical Corporation \_\_\_\_\_ Professional Association \_\_\_\_\_ Other (explain): \_\_\_\_\_

45. Please list all the physician members of your Professional Association, Partnership, Corporation or Entity.

Physician Name	Shareholder	Partner	Employee
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. Do you own or operate any medical business whether related or not to your practice? If YES, please describe the nature of the business enterprise and your affiliation (e.g., owner, employee, independent contractor etc.). Use additional page if necessary. YES  NO

## ANCILLARY COVERAGE

47. Please provide the names and license numbers for the highly trained Healthcare Personnel (as described below) that your practice employs, contracts and/or supervises. Coverage **must** be purchased for these individuals if they do not currently have individual coverage. If you wish to purchase coverage for these employees through our program, we can provide coverage on a Shared Limits basis (one set of limits shared between the employer and ancillary) or on a Separate Limits basis. For those Healthcare Personnel who carry their own coverage, please indicate so below and indicate whether you wish to have vicarious liability coverage provided to you for claims resulting from the providing or failure to provide professional services by such personnel for whose acts you are legally responsible. All other ancillaries (ex. RNs, LPNs & Medical Assistants) will be automatically covered on a Shared Limit basis under the physician/entity's limit.

NAME	LICENSE #	TYPE (Phys/Surg Assistant, Nurse Practitioner, Nurse Midwife, Nurse Anesthetist)	Coverage Requested through Samaritan RRG?		Has Own Coverage (attach certificate) – Vicarious Liability Requested?	
			Separate Limits	Shared Limits	YES	NO
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## ANCILLARY CLAIM INFORMATION

<p><b>48.</b> Regarding the ancillaries named above requesting either shared or separate limits through our program, has any claim or suit for alleged malpractice been brought against any of them?</p> <p><i>* If YES, please have the attached Claim Information Form completed by the ancillary for EACH CLAIM.</i></p>	<input type="checkbox"/> Yes * <input type="checkbox"/> No
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## CLAIM INFORMATION

<p>A "Suit" means a civil proceeding alleging damages for a medical incident, and includes a proceeding in a court, an arbitration proceeding, and any compulsory mediation or court ordered proceeding. A "Claim" means any other request for compensation or relief made on the allegation of damages for a medical incident. A "medical incident" means any act, error or omission in the providing of professional services as a healthcare provider.</p> <p>A "Potential Claim or Suit" includes, without limitation, instances where you have received an oral or written communication from an individual or his legal representative demanding explanations or satisfaction or threatening legal action. It also includes a request by a patient or the patient's legal representative for copies of medical records under circumstances reasonably indicative of a possible claim or suit.</p>					
<p><b>49.</b> Has any claim or suit for alleged malpractice been brought against you or your professional association, partnership or corporation?</p> <p>If <b>YES</b>, please indicate how many claims or suits: _____</p>	<table border="0"> <tr> <td style="text-align: center;"><b>YES</b></td> <td style="text-align: center;"><b>NO</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<b>YES</b>	<b>NO</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>YES</b>	<b>NO</b>				
<input type="checkbox"/>	<input type="checkbox"/>				
<p><b>50.</b> Other than stated in question #48 above, are you aware of any potential claim or suit, or any of the following circumstances that might indicate the possibility of a claim or suit being brought against you, even if you believe the claim or suit would be without merit?</p> <p>a) A request for records from a patient and/or attorney related to an adverse outcome? <input type="checkbox"/> <input type="checkbox"/></p> <p>b) A letter from an attorney regarding your medical treatment of a patient? <input type="checkbox"/> <input type="checkbox"/></p> <p>c) Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? <input type="checkbox"/> <input type="checkbox"/></p> <p>d) Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis? <input type="checkbox"/> <input type="checkbox"/></p> <p>e) Any other circumstances that might indicate the possibility of a claim or suit being brought against you? <input type="checkbox"/> <input type="checkbox"/></p>	<table border="0"> <tr> <td style="text-align: center;"><b>YES</b></td> <td style="text-align: center;"><b>NO</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<b>YES</b>	<b>NO</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>YES</b>	<b>NO</b>				
<input type="checkbox"/>	<input type="checkbox"/>				
<p><b>51.</b> Other than stated in question #48 above, have all circumstances that might indicate the possibility of a claim or suit being made against you (even if you believe the possible claim or suit would be without merit) been reported to your current or prior Professional Liability carrier?: <input type="checkbox"/> <input type="checkbox"/></p> <p>If <b>YES</b>, please indicate the number of potential claims: _____</p> <p><b>Please attach documentation of all such reports.</b></p> <p>If <b>NO</b>, please explain: _____</p>	<table border="0"> <tr> <td style="text-align: center;"><b>YES</b></td> <td style="text-align: center;"><b>NO</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<b>YES</b>	<b>NO</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>YES</b>	<b>NO</b>				
<input type="checkbox"/>	<input type="checkbox"/>				
<p><b>52.</b> If you are NOT AN OBSTETRICIAN, have you ever been involved in an obstetrical case regardless of whether case is open, or closed or whether a payment was made or not made? <input type="checkbox"/> <input type="checkbox"/></p>	<table border="0"> <tr> <td style="text-align: center;"><b>YES</b></td> <td style="text-align: center;"><b>NO</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<b>YES</b>	<b>NO</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>YES</b>	<b>NO</b>				
<input type="checkbox"/>	<input type="checkbox"/>				
<p><b>53.</b> Have you ever been involved in a case where it has been proven that alteration of medical records has occurred, regardless of whether case is closed or if a payment was made or not made? <input type="checkbox"/> <input type="checkbox"/></p>	<table border="0"> <tr> <td style="text-align: center;"><b>YES</b></td> <td style="text-align: center;"><b>NO</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<b>YES</b>	<b>NO</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>YES</b>	<b>NO</b>				
<input type="checkbox"/>	<input type="checkbox"/>				
<p><b>54.</b> Have any unexpected or potentially problematic results/incidents/reported claims occurred in the following categories?:</p> <p>a) Death; <input type="checkbox"/> <input type="checkbox"/></p> <p>b) Loss of Function: <input type="checkbox"/> <input type="checkbox"/></p> <p>c) An impairment requiring long term/permanent care as a result of treatment rendered: <input type="checkbox"/> <input type="checkbox"/></p> <p>d) Post-operative coma or neurological deficits <input type="checkbox"/> <input type="checkbox"/></p> <p>e) All others (please explain): <input type="checkbox"/> <input type="checkbox"/></p>	<table border="0"> <tr> <td style="text-align: center;"><b>YES</b></td> <td style="text-align: center;"><b>NO</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<b>YES</b>	<b>NO</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>YES</b>	<b>NO</b>				
<input type="checkbox"/>	<input type="checkbox"/>				

(A Separate Incident/Claim Information Form **MUST** be completed for each incident, potential claim, claim or suit.)  
Please make copies of this blank form as needed.

**Note: If there are none to report,  
please indicate "N/A" and sign the blank form.**

INCIDENT/CLAIM INFORMATION FORM (Past or Pending)

If you answered YES to any item in Questions 49-54, you must complete this form with respect to any incident, potential claim, claim or suit against you. Photocopy this form if you have more than one incident, potential claim, claim or suit to report. (Attach all supplemental information necessary.)

1. Physician Name / Healthcare Ancillary Name:		
2. a) Patient/Claimant name:	b) Age	c) Gender
3. a) Physical condition and diagnosis at time of incident:	b) Date of first consultation:	
4. a) Date of incident or occurrence from which claim resulted:	b) Date claim was filed:	
5. a) Description of treatment rendered:	b) Alleged Date of Loss:	
6. Allegations made against you (state injury or damages alleged): _____ _____ _____		
7. Subsequent condition or health of patient:		
8. Was this claim reported to your insurance carrier (if YES, list name of carrier and policy number):		<input type="checkbox"/> Yes <input type="checkbox"/> NO
Carrier Name:	Policy Number:	Date Reported:
9. Present status or disposition of claim including amount of settlement or judgement:		
<input type="checkbox"/> Open	<input type="checkbox"/> Closed	Amount Paid on Your Behalf: \$ _____
Date Closed ____/____/____	Total Amount Paid on Claim (inc other defendants): \$ _____	
I hereby authorize release to Aon Risk Services and its agents for information from my insurance carriers, their adjusting firms, and attorney concerning past or present claim matters in which I am involved.		
<b>X</b> _____ Signature of Applicant	<b>X</b> _____ Date of Signature	
<small>(A photostatic copy of this authorization shall be considered as effective and as valid as the original. Each incident/claim information form must have physician's original signature.)</small>		

**PLEASE READ AND SIGN**

I certify that any and all answers given above represent full and true disclosure of the facts sought by Aon Risk Services, Inc. I understand and agree that any misrepresentation, omission, or misstatement of fact in this application that is material to the risk shall be grounds for rescission of all coverage granted pursuant to this application.

I understand that the information given is confidential and will be used only for medical professional liability evaluation.

I understand that any and all answers to the above questions are subject to verification, and that all required documentation must be furnished, that significant discrepancies will require clarification on my part before the application can be considered.

I understand that acceptance of the application for individual coverage does not necessarily mean that my request for Prior Acts Coverage will be accepted.

I hereby certify that following careful review of my professional activities, including patient records, I have reported to my present insurance carrier all claims, suits, or potential claims or suits, as defined in the application, in which I am involved or in which I may become involved, arising out of events that took place during the period of my coverage with my present carrier. I understand that I will not have coverage for claims or suits, or potential claims or suits, which were or should have been reported to my present carrier or any former carrier.

I understand that disapproval of my application in no way represents a reflection upon me personally or upon my qualifications as a practitioner of medicine. I further understand and agree that if my application is not approved, the reason(s) for its disapproval will be kept in strict confidence. I hereby agree to release from liability for slander, libel, defamation of character, or any and all other causes of action, Aon Risk Services, Inc. and all of its directors, agents, officers, employees, designees, committees, or committee members.

**I AGREE TO IMMEDIATELY NOTIFY AON RISK SERVICES, INC. IN WRITING, IF THERE IS ANY CHANGE IN ANY ANSWER GIVEN IN MY APPLICATION INCLUDING ANY CHANGE IN MY PROFESSIONAL STATUS AND I UNDERSTAND AND AGREE THAT SUCH CHANGES ARE MATERIAL TO THE RISKS COVERED BY THE CARRIER I AM APPLYING FOR.**

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

**X**

\_\_\_\_\_  
PRINT OR TYPE NAME OF APPLICANT

**X**

\_\_\_\_\_  
Signature of Applicant

**X**

\_\_\_\_\_  
Date of Signature



## Claims History Request

Company:

---

Attention:

---

Phone:

---

Fax:

---

Insured Name:

---

License Number:

---

Insured Phone:

---

DOB:

---

Policy Number:

---

Please provide my agent recognized below with a Currently Valued Loss Run including Policy Period Coverage dates for my professional liability coverage for the above referenced policy number. Please fax my loss history to the number listed below:

Carlota Redondo  
Account Specialist  
Aon Risk Services, Inc. of Florida  
1001 Brickell Bay Drive, Suite 1100  
Miami, FL 33131  
Phone: (305) 961-6125  
Fax: (305) 372-8770

Thank you for your prompt attention to this matter.

Sincerely,

---

Signature

---

Date

# Samaritan Risk Retention Group

*A Baptist Health South Florida-sponsored Program*

## Acknowledgement of No Prior Acts Coverage

I, \_\_\_\_\_, understand that my professional liability policy to be issued by Samaritan Risk Retention Group, Inc. with an effective date of \_\_\_\_\_ will not provide prior acts coverage. I am fully aware if a claim arises from my performing professional services or my failure to perform professional services to a patient which services occurred prior to \_\_\_\_\_ that no coverage will be provided by the policy to be issued effective \_\_\_\_\_.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Baptist Health  
South Florida**

BAPTIST HOSPITAL OF MIAMI • SOUTH MIAMI HOSPITAL • DOCTORS HOSPITAL  
BAPTIST CHILDREN'S HOSPITAL • HOMESTEAD HOSPITAL • MARINERS HOSPITAL  
BAPTIST OUTPATIENT SERVICES • BAPTIST CARDIAC & VASCULAR INSTITUTE