PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Hickory Pointe, Suite 125, 2250 Hickory Road, Plymouth Meeting, PA 19462
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com – Website: http://www.pajua.com

APPLICATION FOR PHYSICIAN'S PROFESSIONAL LIABILITY INSURANCE
Limits of Liability: $500,000 Per Occurrence / $1,500,000 Per Annual Aggregate

POLICIES ARE ISSUED ON AN ANNUAL BASIS UNLESS OTHERWISE SPECIFIED AND APPROVED BY THE JUA
COVERAGE CANNOT BEGIN PRIOR TO APPLICATION AND PREMIUM RECEIPT BY THE JUA

Applicant's Name: _____

First Middle Last Title (MD or/ DO)

Coverage Requested: ☐ **Occurrence** ☐ **Claims-Made** **Requested Effective Date:**

Requested Retroactive Date:

Expiration Date less than 1 year (short-term policy):

Reason for short-term policy:

Part I - General Information

Home Address: _____
Number and Street City State Zip

Principal Business Address: _____
Number and Street City State Zip

Preferred Mailing Address: ☐ Home ☐ Business ☐ Other (Use an attachment to list and explain)

Business Phone: _____ **Home Phone:** _____

Business Fax: _____ **E-mail Address:** _____

Date of Birth: _____

PA Medical License No.: _____ **Federal DEA No.:** _____

Part II – Broker Information: (If this is being submitted by an insurance broker):

Broker: _____ **Contact Person:** _____

Phone: ____ _____ **Fax No.** ____ _____ **E-Mail Address:** _____

Address: _____
Number and Street City State Zip

EIN or SS No.: (If "new" to JUA) _____

Part III – Coverage Information:

List ALL Prior Insurers for the last 10 years – include all places of employment: (attach separate list if necessary)

Carrier or Self-Insurer	Policy Number	Coverage Dates (Month, Day & Year) Eff. Exp.	Coverage Type (Occurrence or Claims-Made)	Retroactive Date (if Claims-Made)	Tail Coverage Purchased?
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No

If any of the above policies are still in force, explain why coverage is requested from the JUA:

_____

Explain any gaps in coverage in the past 8 years including any period directly preceding JUA coverage:

_____

Explain why tail coverage was not purchased for any claims-made policy listed above:

_____

Attach a copy of your current Declarations, current CV (initialed and dated) and Policy History / Claim History Reports from each of the above carriers or self-insurers plus Mcare.
You need to contact each of your current or prior carriers and request they send you these reports. They are required to provide these reports to you if you request them. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if you have had no claims.

Applicant's Signature (all pages must be signed): _____ _____
(Name if typing application, type in name) (date)

Claims or Suits:
Have any claims been made or suits brought against you during the past 10 years as a result of professional services rendered? (Regardless of whether the claim was dismissed or a judgment rendered) ☐ Yes ☐ No If yes, attach a description of all claims made or suits brought including the date and status.

Medical Incidents:
Are you aware of any medical incidents which occurred during one of the claims-made policies *for which a claim has not yet been made*? ☐ Yes ☐No If yes, attach a complete description of the incidents including the date and status.

Never Events:
Have any claims been made or suits brought against you for an incident where the patient's medical insurance or Medicare refused to pay because it was on their preventable serious adverse event or "never event" list? ☐ Yes ☐ No
If yes, attach a description of the incident including the date and status.

Part IV – Locations (AT LEAST ONE LOCATION MUST BE LISTED – all locations must total 100%):
List ALL locations and hospitals at which you will practice during the policy period (even if outside Pennsylvania). Base percentage of practice on the number of patients. (Use additional pages if needed.)

Practice Locations:

1. _____ _____
Suite Number & Street City State County Zip Phone % of Practice

2. _____ _____
Suite Number & Street City State County Zip Phone % of Practice

3. _____ _____
Suite Number & Street City State County Zip Phone % of Practice

Hospital Locations:

1. _____ _____
Name of Hospital City State County Type of Privileges % of Practice

2. _____ _____
Name of Hospital City State County Type of Privileges % of Practice

3. _____ _____
Name of Hospital City State County Type of Privileges % of Practice

If any of the above are not to be covered, please list facility/location names and addresses here. Use additional pages if needed. No coverage will be provided for locations outside Pennsylvania.

History:
List other locations and hospitals at which you have practiced in the past 10 years (use additional pages if needed):

1. _____ _____
Address or Name of Hospital City State County Dates of practice

2. _____ _____
Address or Name of Hospital City State County Dates of practice

Part V – Educational Background (attach separate sheet if needed to fully describe)

Medical School: _____ **Year Graduated:** _____
Location of School: _____ **Degree:** _____
City State Country

If this is a foreign medical school, are you certified by the Educational Council for Medical School Graduates? ☐Yes ☐No

Internship: _____
Name of Hospital City State
From _____ to _____ Type of Internship _____
Month/Year Month/Year

Residency: _____
Name of Hospital City State
From _____ to _____ Type of Residency Completed: _____
Month/Year Month/Year

Residency: _____
Name of Hospital City State
From _____ to _____ Type of Residency Completed: _____
Month/Year Month/Year

Additional Training/Fellowship:
_____
Name of Hospital City State
From _____ to _____ Type of Training Completed: _____
Month/Year Month/Year

Applicant's Signature (all pages must be signed): _____ _____
(Name if typing application, type in name) (date)

Board Certification: Are You Board Certified? ☐ Yes ☐ No
If Yes, list Board Certificates and date certified:

Part VI – Rating Information

1. What is your Medical Specialty? _____
Other Specialty? _____ Sub-Specialty? _____
Describe the practice for which you are applying for JUA coverage. Attach a separate page if necessary:

2. Procedures and Practices *(at least one column must be checked for each item on the list)*
In **Column A** check the box for all of those items applicable to the practice for which you are applying for JUA coverage.
In **Column B** check the box for all of those that applied to your practice at any time **During the Last 10 Years**.
If neither Column A or B apply, check the box in the column labeled **No**

Col. A	Col. B	No		Col A	Col. B	No	
☐	☐	☐	Minor Surgery (see last page for definitions)	☐	☐	☐	Lithotripsy
☐	☐	☐	Major Surgery (see last page for definitions)	☐	☐	☐	Interventional Radiology
☐	☐	☐	Assistance in Major Surgery on own patients only	☐	☐	☐	Deep Radiation / X-ray Therapy – (Over 120 K.V.)
☐	☐	☐	Assistance in Major Surgery on other than own patients	☐	☐	☐	Contrast Material: Injection, supervision of others who inject, reading images
☐	☐	☐	Colon-Rectal Surgery: ____ % of surgical practice	☐	☐	☐	Swan Ganz Catheterization only
☐	☐	☐	Bariatric / Intestinal Surgery for Obesity	☐	☐	☐	Left or Right Heart Catheterization
☐	☐	☐	Laser Surgery (describe)				
☐	☐	☐	Biopsy (List types)	☐	☐	☐	Plastic Surgery
☐	☐	☐	Fracture Reduction – Open	☐	☐	☐	BoTox Injections (describe purpose)
☐	☐	☐	Fracture Reduction – Closed	☐	☐	☐	Dermal Fillers (List types)
				☐	☐	☐	Light Chemical Peels (List types)
☐	☐	☐	Prenatal care through 1st trimester	☐	☐	☐	Medium Chemical Peels (List types)
☐	☐	☐	Prenatal care through 2nd trimester	☐	☐	☐	Deep Chemical Peels (List types)
☐	☐	☐	Prenatal care through 3rd trimester	☐	☐	☐	Dermabrasion
☐	☐	☐	Caesarian Sections	☐	☐	☐	Sclerotherapy
☐	☐	☐	Normal Obstetrical Deliveries	☐	☐	☐	Mesotherapy
☐	☐	☐	Abortions	☐	☐	☐	Laser Therapy (List types)
				☐	☐	☐	Liposuction (List types)
☐	☐	☐	Administration of general, spinal or caudal anesthesia	☐	☐	☐	Blepharoplasty (indicate cosmetic or functional)
☐	☐	☐	Epidurals	☐	☐	☐	Hair removal (List types)
☐	☐	☐	Facet Injections	☐	☐	☐	Hair Transplant (List types)
☐	☐	☐	Trigger Point Injections	☐	☐	☐	Other Aesthetic/Cosmetic Procedures (provide list)
☐	☐	☐	Other Nerve Blocks (List types)				
☐	☐	☐	Spinal Cord Stimulation				
☐	☐	☐	Endoscopic Procedures (List types)	☐	☐	☐	Complementary and Alternative Medicine Procedures (provide list)
☐	☐	☐	Sigmoidoscopy greater than 60 cm	☐	☐	☐	Chelation Therapy
☐	☐	☐	Polypectomy	☐	☐	☐	Addiction Medicine

Details/descriptions/lists/type for above:

Applicant's Signature (all pages must be signed): _____ _____
(Name if typing application, type in name) (date)

3. How many hours per week are generally spent in the practice of your medical profession? _____

4. If only a portion of your practice is to be covered by this insurance, how many hours per week are generally spent in the portion of your practice to be covered? _____

5. Do you serve in a hospital emergency room? ☐ Yes ☐ No If yes, how many hours per week? _____

6. Do you serve in a prison environment? ☐ Yes ☐ No If yes, how many hours per week? _____

7. Do you practice at a wound care clinic or center? ☐ Yes ☐ No If yes, how many hours per week? _____
Clinic/Center name and address: _____

8. Do you provide follow-up care for patients who have had health care services performed outside Pennsylvania?
☐ Yes ☐ No If yes, provide: a description of the services performed outside Pennsylvania; the locations where the services were performed; and description of the follow-up care that you provide in Pennsylvania. Attach a separate page if necessary:

_____

9. Do you employ or supervise any of the following health care professionals: ☐ Yes ☐ No If yes, check all that apply:
☐ Nurse Midwives: Number employed/supervised: _____
☐ Nurse Anesthetists Number employed/supervised: _____
☐ Physician Assistants Number employed/supervised: _____
☐ Nurse Practitioners Number employed/supervised: _____
☐ Physical Therapists Number employed/supervised: _____
Are there written protocols? ☐ Yes ☐ No
Do these health care professionals carry their own individual medical professional liability coverage? ☐ Yes ☐ No
Describe the health care professionals' duties, including extent supervised by you (use separate page if needed):
_____
Do you act as collaborating physician for any of the above? ☐ Yes ☐ No
If yes, who? _____

10. Will you be performing professional activities that will be covered by another professional liability policy?
☐ Yes ☐ No If yes: Other practice description and location _____
At the other practice are you an ☐ employee or ☐ independent contractor?
Name of other insurance company and policy number: _____

11. Do you participate as a member of any medical peer review or accreditation board or group? ☐ Yes ☐ No
If yes, give details: _____

12. Are you a Medical Director or Department Head of a hospital, nursing home, clinic, commercial enterprise or any other organization? ☐ Yes ☐ No If yes, provide position/title, organization name and location:
_____

13. Do you obtain a signed Informed Consent form from each patient prior to providing services? ☐ Yes ☐ No
If no, please explain: _____
If yes, please answer all of the following questions:
Is the consent form procedure specific? ☐ Yes ☐ No Is it witnessed? ☐ Yes ☐ No
Is the consent form reviewed orally with the patient? ☐ Yes ☐ No Is the patient provided a copy? ☐ Yes ☐ No
How do you handle language problems? _____

14. Do you use Electronic Health Records (EHR) / Electronic Medical Records (EMR) at the practice for which you are applying for JUA coverage? ☐ Yes ☐ No **If yes**, please answer all of the following questions:
What is the name of the EHR/EMR system? _____
Is the EHR/EMR system certified? ☐ Yes ☐ No Name of certifying body: _____
How long has the system been in use? _____ Is all or part of the system in use? ☐ All ☐ Part
What type of training has been provided to you and your staff? _____
How is data protected? _____
Is there a process in place to receive regular or available system updates? ☐ Yes ☐ No

15. Do you provide any remote services (e.g. on the internet, telemedicine)? ☐ Yes ☐ No
If yes, please answer all of the following questions. If no, skip to Question 16.
Describe the remote services you provide. Attach a separate page if necessary.
_____
Are any slides, specimens, images, test results, data, etc. generated and sent to you from outside Pennsylvania?
☐ Yes ☐ No If yes, list locations and types: _____
Do you provide remote services to patients who are located in their homes or at medical facilities? ☐ Yes ☐ No
If yes, the patients are (check all that apply): ☐ Located at home ☐ Located at medical facilities
Are the remote patients referred to above pre-existing patients previously seen in person either by you or another health care provider who has referred the patients to you? ☐ Yes ☐ No
Do you remotely treat pre-existing patients for new symptoms? ☐ Yes ☐ No

Applicant's Signature (all pages must be signed): _____ _____
(Name if typing application, type in name) (date)

Are the remote patients advised to see a health care provider in person if symptoms do not improve? ☐ Yes ☐ No
Are any of the remote patients located outside Pennsylvania? ☐ Yes ☐ No If yes, list locations:

_____

16. Do you maintain a website, blog or other internet or electronic media site? ☐ Yes ☐ No
If yes, provide name of site: _____

17. Have any aspects of your practice changed in the past **5 years**? ☐ Yes ☐ No
If yes, give details including dates of change:

_____

Part VII – Practice Organization

Please check the box that describes the practice for which you want insurance:

☐ Sole Proprietor/Unincorporated
☐ Employee of individual/group (not a shareholder)
☐ Corporate shareholder
☐ Government employee
☐ Independent contractor
☐ Sole Corporation
☐ Partner or partnership
☐ Hospital employee
☐ Industrial employee
☐ Other (describe) _____

1. Name of corporation, partnership or employer: _____

2. Do you wish coverage for your Professional Corporation or Partnership? ☐ Yes ☐ No
If yes, a separate corporation/partnership application is required for each entity.
If no, is the corporation/partnership insured elsewhere? ☐ Yes ☐ No
Name of entity's insurance company and policy number: _____

Part VIII – Licenses

Have you ever been licensed in a state other than Pennsylvania? ☐ Yes ☐ No If yes, provide information below:

State	License Number	Date Received	Currently Active?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Part IX – Additional Professional Information

1. Have your staff privileges, license to practice, participation in any Medicaid or Medicare program, or ability to prescribe drugs ever been revoked, suspended, placed on probation, voluntarily surrendered or subject to reprimand or fine?
☐ Yes ☐ No If yes, provide details. Attach a separate page if necessary.

_____

2. Have you ever been charged or convicted of any crime, or are you currently under investigation for a criminal act, other than minor traffic violations? ☐ Yes ☐ No If yes, provide details. Attach a separate page if necessary.

_____

3. Has a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by any regulatory agency? ☐ Yes ☐ No If yes, provide details. Attach a separate page if necessary.

_____

Applicant's Signature (all pages must be signed): _____ _____
(Name if typing application, type in name) (date)

DEFINITIONS

* Major Surgery:
  Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis: any other operation which, because of the condition of the patient, or the length or circumstances of the operation, presents a distinct hazard to life. It also includes but is not limited to: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation performed under general anesthesia.

* Minor Surgery:
  Any operation not defined as Major surgery.

* No Surgery
  The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.

ORDERING MCARE LOSS HISTORIES

Request must be in writing and signed by the insured health care provider.
Must include health care provider's name and PA license number.
Include address of where loss runs are to be sent.
Requests are to be sent to:

Jackie Haynes
Mcare Fund
1062 Lancaster Avenue, Suite 15F
Rosemont, PA 19010

Jackie's telephone number: (610) 801-2200 x 3040
Jackie's fax number: (610) 801-2211
Jackie's email address: jhaynes@state.pa.us
There is no fee involved for requesting the loss runs.

APPLICATION CERTIFICATION

I certify that I will not accept insurance from the JUA if I am able to obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers.

I authorize the JUA to obtain full information from any person or organization with respect to claims or suits and consent to the release of information by any hospital, medical staff, licensure board or other professional practice data source regarding any information they may have concerning my prior professional activities. This is a continuing authorization for as long as I have coverage with the JUA and thereafter in connection with any issue pertaining to such coverage.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information which is calculated to influence the judgment of the JUA in considering this application.

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.

Applicant's Signature (all pages must be signed): _____ _____
(Name if typing application, type in name) (date)

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Supplemental Claims Information Form

Complete one form for each claim. Download additional copies of this form as needed (see website for separate form)

Applicant's Name:

_____

First Middle Last

PA Medical License No.: _____

Carrier's Claim Number or Claimant's Name:

_____

Incident Date: _____
(Month, Day and Year)

Date Reported: _____
(Month, Day and Year)

Location Where Incident or Alleged Injury Occurred: _____

Carrier Name: _____

Policy Number: _____ Effective Date: _____

Status (check all that apply):

☐ Open ☐ Closed Date Closed: _____

☐ Settlement ☐ Judgment ☐ Dismissed

Amount of Indemnity Payment (if any): $_____

Description of Claim: