

**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](mailto: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:** \_\_\_\_\_  M.D.  D.O.  
 First Name Middle Name Last Name

**Coverage Requested:**  Occurrence  Claims-Made **Requested Effective Date:** \_\_\_\_\_  
**Requested Retroactive Date:** \_\_\_\_\_

**Coverage Period if less than 1 year (short-term policy):** From: \_\_\_\_\_ To: \_\_\_\_\_  
**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:** \_\_\_\_\_ **Social Security No.:** \_\_\_\_\_  
**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?
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> 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) \_\_\_\_\_ (date)  
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**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 "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 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 indicate (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:

1. \_\_\_\_\_  
Address or Name of Hospital                      City      State      County                      Dates of practice
2. \_\_\_\_\_  
Address or Name of Hospital                      City      State      County                      Dates of practice
3. \_\_\_\_\_  
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:** \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_ Type of Internship \_\_\_\_\_  
Month/Year                      Month/Year

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

From \_\_\_\_\_ to \_\_\_\_\_ Type of Residency Completed: \_\_\_\_\_  
Month/Year                      Month/Year

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

From \_\_\_\_\_ to \_\_\_\_\_ Type of Residency Completed: \_\_\_\_\_  
Month/Year                      Month/Year

**Additional Training/Fellowship:**

From \_\_\_\_\_ to \_\_\_\_\_ Type of Training Completed: \_\_\_\_\_  
Month/Year                      Month/Year

Applicant's Signature (all pages must be signed): \_\_\_\_\_ (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? \_\_\_\_\_  
 Briefly describe the practice for which you wish coverage: \_\_\_\_\_

**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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minor Surgery (see last page for definitions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lithotripsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery (see last page for definitions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interventional Radiology
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistance in Major Surgery on own patients only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deep Radiation / X-ray Therapy – (Over 120 K.V.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistance in Major Surgery on other than own patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contrast Material: Injection, supervision of others who inject, reading images
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon-Rectal Surgery: ____ % of surgical practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swan Ganz Catheterization only
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bariatric / Intestinal Surgery for Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left or Right Heart Catheterization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laser Surgery (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plastic Surgery
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biopsy (List types)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BoTox Injections (describe purpose)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fracture Reduction - Open	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dermal Fillers (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fracture Reduction – Closed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light Chemical Peels (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal care through 1st trimester	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medium Chemical Peels (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal care through 2nd trimester	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deep Chemical Peels (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal care through 3rd trimester	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dermabrasion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caesarian Sections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sclerotherapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Normal Obstetrical Deliveries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mesotherapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abortions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laser Therapy (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Administration of general, spinal or caudal anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liposuction (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epidurals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blepharoplasty (indicate cosmetic or functional)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facet Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair removal (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trigger Point Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair Transplant (List types)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Nerve Blocks (List types)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Aesthetic/Cosmetic Procedures (provide list)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complementary and Alternative Medicine Procedures (provide list)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endoscopic Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chelation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sigmoidoscopy greater than 60 cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Addiction Medicine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polypectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Details/descriptions/lists/type for above:


Applicant's Signature (all pages must be signed): \_\_\_\_\_ (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 surgery performed in a state other than Pennsylvania?  
 Yes  No If yes, describe types of surgery and the care you provide: \_\_\_\_\_
- Do you provide follow-up care for patients who have had surgery performed outside the United States?  
 Yes  No If yes, describe types of surgery and the care you provide: \_\_\_\_\_
9. Do you employ or supervise any of the following health care professionals:  Yes  No (Check all that apply.)  
 Nurse Midwives\* Number employed/supervised: \_\_\_\_\_  
 CRNA's\* Number employed/supervised: \_\_\_\_\_  
 Physician Assistants\* Number employed/supervised: \_\_\_\_\_  
 Nurse Practitioners\* Number employed/supervised: \_\_\_\_\_  
 Physical Therapists\* Number employed/supervised: \_\_\_\_\_  
 Other Than Above (describe) \_\_\_\_\_ 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 duties, including extent supervised (use separate page if needed): \_\_\_\_\_
10. Will you be performing professional activities that will be covered by another professional liability policy?  
 Yes  No If yes: Practice description and location: \_\_\_\_\_  
 Are you  an employee  independent contractor  
 Name of 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, give details: \_\_\_\_\_
13. Do you obtain a signed Informed Consent form from each patient prior to providing services?  Yes  No  
If no, please explain why not: \_\_\_\_\_  
 If yes, 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 are language problems handled? \_\_\_\_\_
14. Do you use Electronic Health Records (EHR) / Electronic Medical Records (EMR)?  Yes  No  
 If yes, 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, give details: \_\_\_\_\_
- What types of interpretations do you provide? (Check all that apply.)  
 Preliminary reports  Final reports  Second opinion/Consultation  Emergency  
 Do you sign any of the reports?  Yes  No If yes, which ones? \_\_\_\_\_  
 Do you sign any reports which you have not personally interpreted?  Yes  No  
 Are you credentialed at the facilities from which the slides, specimens, or images are sent and received?  Yes  No  
 Are any slides, specimens, images etc. sent from a state other than Pennsylvania?  Yes  No  
 Are any slides, specimens, images etc. sent from outside the United States?  Yes  No
16. Have any aspects of your practice changed in the past **5 years**?  Yes  No  
 If yes, give details including dates of change: \_\_\_\_\_

Applicant's Signature (all pages must be signed): \_\_\_\_\_ (Name) \_\_\_\_\_ (date)

**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

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 insurance company and policy number: \_\_\_\_\_

**Part VIII – Licenses**

Have you ever been licensed in a state other than Pennsylvania?  Yes  No If Yes:

State	License Number	Date Received	Currently Active?
			<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"/> Yes <input type="checkbox"/> 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, give details: \_\_\_\_\_
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, give details: \_\_\_\_\_
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, give details: \_\_\_\_\_

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) \_\_\_\_\_ (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:

Natalie McLaughlin

Mcare Fund

1062 Lancaster Avenue, Suite 15F

Rosemont, PA 19010

Natalie's telephone number: (610) 801-2200 x 3016

Natalie's fax number: (610) 801-2211

Natalie's email address: nmclaughli@state.pa.us

There is no fee involved for requesting the loss runs.

**PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION**

**Supplemental Claims Information Form**

Complete one form for each claim. Make additional copies of this form as needed.

Applicant's Name: \_\_\_\_\_  
(First) (Middle) (Last)

License Number: \_\_\_\_\_

Claimant's Name: \_\_\_\_\_  
(First) (Middle) (Last)

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:

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