

<b>Applicant's Name:</b>			<b>DPM</b>
First Name	Middle Name	Last Name	
<b>Coverage Requested:</b>	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<b>Requested Effective Date:</b>	
<b>Coverage period if less than 1 year:</b>	<b>From:</b>	<b>To:</b>	
		<b>Requested retroactive date</b>	
<b>(Coverage cannot begin prior to application and premium receipt by the JUA)</b>			

**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)

**Application For Podiatrist's Professional Liability Insurance**  
**Limits of Liability: \$500,000 Per Occurrence / \$1,500,000 Per Annual Aggregate**

<b>Part I - General Information</b>					
<b>Home Address:</b>					
Number and Street	City	State	Zip		
<b>Principal Business Address:</b>					
Number and Street	City	State	County	Zip	
<b>Preferred Mailing Address:</b>					
	Home	Business	Other (Use an attachment to list and explain)		
<b>Business Phone:</b>	( )		<b>Home Phone:</b>	( )	
<b>Business Fax:</b>	( )		<b>E-mail Address:</b>		
<b>Date of Birth:</b>		<b>Social Security No.:</b>			
<b>PA Medical License No.:</b>		<b>Federal DEA No.:</b>			
<b>Part II – Broker Information: (If this is being submitted by an insurance broker):</b>					
<b>Broker:</b>		<b>Contact Person:</b>			
<b>Phone:</b> ( )	<b>Fax No.:</b> ( )	<b>E-Mail Address:</b>			
<b>Address:</b>					
Number and Street	City	State	Zip		
If "new" to JUA:					
<b>EIN or SS No:</b>					
<b>Part III – Coverage Information:</b>					
<b>List all Prior Insurers for the last 10 years – include all places of employment: (attach separate list if necessary)</b>					
Carrier or Self-Insurer	Policy Number	Coverage Dates Eff.	Exp.	Coverage (Occurrence or Claims-Made)	Retroactive Date/Comments
				Occ CM	
				Occ CM	
				Occ CM	
				Occ CM	
				Occ CM	
<b>If any of the above policies are still in force, explain why coverage is needed from the JUA:</b>					
Have any claims been made or suits brought against you during the past 10 years as a result of professional services rendered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a description of all claims made or suits brought.					
<b>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.</b>					
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.					
<b>Medical Incidents:</b>					
Are you aware of any medical incidents which occurred during one of the claims-made policies <i>for which a claim has not yet been made?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a complete description of the incidents including the date and status of the incident.					

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



**Part VII – 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 your practice **Now** and **During the Coverage Period**.  
 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**

No	Col. A	Col. B	No	Col. A	Col. B
		Excision of Verruca			Bursectomy
		Debridement of Ulcer (not exceeding Wagner Grade II)			Excision of Neuroma
		Avulsion of Toe Nail (Partial or Total)			Arthroplasty – Digits
		Avulsion of Toe Nail and Matrisectomy (Partial or Total)			Tenotomy – Extensor Lessor Digits
		Incision and Drainage – Superficial Abscess			Subungual Exostectomy
		Incision and Drainage – Deep Abscess			Heel Spur Resection
		Excision of Ganglion			Capsulotomy - Forefoot
		Osteotripsy			Hallux Valgus Repair

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. 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: \_\_\_\_\_
8. Do you participate as a member of any medical peer review or accreditation board or group? Yes No  
 If yes, give details: \_\_\_\_\_
9. 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: \_\_\_\_\_
10. Do you provide any remote services (e.g. on the internet, telemedicine)? Yes No  
 If yes, give details: \_\_\_\_\_  
 If yes, are any slides, specimens, images etc. sent from a state other than Pennsylvania?  Yes  No
11. With respect to the *above questions* have any aspects of your practice changed in the past **2 years**? Yes No  
 If yes, give details: \_\_\_\_\_

**Part VIII – Practice Organization**

Please check the box that describes your practice:

- |   |   |
|---|---|
| <input type="checkbox"/> Sole Proprietor/Unincorporated                   | <input type="checkbox"/> Sole Corporation       |
| <input type="checkbox"/> Employee of individual/Group (not a shareholder) | <input type="checkbox"/> Partner or partnership |
| <input type="checkbox"/> Corporate shareholder                            | <input type="checkbox"/> Hospital employee      |
| <input type="checkbox"/> Government employee                              | <input type="checkbox"/> Industrial employee    |
| <input type="checkbox"/> Independent contractor                           |   |

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

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

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

**DEFINITIONS**

\* Surgery is any procedure that requires any form of anesthesia (topical, local, regional, general, or I.V. gaseous sedation). Post-operative treatment is considered part of a surgical procedure. However, podiatrists covered under a non-surgical policy may do nail surgery or excise superficial skin lesions, as long as an incision below the dermis is not required. Therefore, the excision of warts, molluscum, contagiosum and papilloma is covered. Surgical debridement of ligaments, tendons and/or bone is are surgical procedures.

Treating ulcers (not exceeding Wagner Grade II), including those with localized infection is a non-surgical procedure.

**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.

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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 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 with 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)