

## CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR PHYSICIANS & SURGEONS

### Application Instructions & Checklist

**Prior to completing the application, please read the following instructions. Please verify that all required attachments are included in order to assist us in processing your application promptly.**

#### Instructions

- 1 Please type or print.
- 2 Answer all questions. If a question does not apply, mark "N/A" (Not Applicable). Do not leave any question unanswered. If an answer requires more detail, please use the **Remarks Section** or attach additional documentation.
- 3 Application must be signed and dated by the owner, partner or officer.
- 4 Please carefully read the statements at the end of the application.

#### Required Attachments

- Please attach a copy of your **CURRENT curriculum vitae (CV)** - CV must include medical school training and practice history information.
- Please attach a copy of your **CURRENT Declarations Page** from your current policy showing your policy period, limits of liability, and retroactive date.
- Please attach a copy of your **CURRENT loss runs** from all insurance carriers that insured you for the past seven years (if applicable).
- Please attach a copy of your **CURRENT letterhead**.

**Please submit the completed application and the required attachments by email, fax, or mail to:**

Fairway Physicians Insurance Company, RRG ("FAIRWAY")  
30401 Agoura Road, Suite 101  
Agoura Hills, CA 91301  
Fax (818) 979-8003  
Email [submissions@fairwayphysicians.com](mailto:submissions@fairwayphysicians.com)

**If you need assistance with the application,  
please call (800) 859-7013 to speak with a FAIRWAY Representative.**

NOTICE: This application is issued by your risk retention group. Your risk retention group may not be subject to all insurance laws and regulations of your state. State insurance insolvency guaranty funds may not be available for your risk retention group.

# CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR PHYSICIANS & SURGEONS

Requested Effective Date: MM/DD/YYYY Requested Retroactive Date: MM/DD/YYYY

## Contact Information

- 1 Name: First M.I. Last Title:
- 2 Date of Birth: MM/DD/YYYY Social Security Number:  Gender:  Male  Female
- 3 Driver's License #:  Employer IRS #:
- 4 Primary Office Address: Street City State Zip Code  
Office Phone:  Office Fax:   
Email:  Website:   
Contact Person:
- 5 Home Address: Street City State Zip Code  
Home Phone:  Mobile Phone:
- 6 Please list all other office locations for which you are requesting coverage.
- 7 Please list all hospitals where you have privileges.
- 8 Please indicate billing address:  Primary Office  Home  Other
- 9 How did you hear about FAIRWAY?

## Practice Information

- 10 Primary Specialty:  % of Practice:   
Secondary Specialty:  % of Practice:
- 11 Are you ABMS Certified?  Yes  No If Yes, date of certification or recertification: MM/DD/YYYY
- 12 Are you Board Eligible?  Yes  No Date of Board Exams taken by you: MM/DD/YYYY
- 13 Please list all medical licenses (State, License #):
- 14 Please indicate your average total number of hours worked per week:
- 15 Please estimate the number of patient visits per week:
- 16 Practice type:  Partnership  Corporation  Individual  Solo/Proprietor Using a DBA  
 Employee  Office Sharing Arrangement  Member of a Multiperson Corporation/Association

**Practice Information (Continued)**

17 Name of Entity: \_\_\_\_\_ DBA: \_\_\_\_\_

18 Please list the names of all physicians and surgeons you employ, contract with, supervise and/or practice with in an office setting.

\* If you are requesting coverage with FAIRWAY, each physician must complete their own Physicians & Surgeons Application and coverage is subject to underwriting approval and payment of premium.

19 With whom do you share call?

20 Please list the names of all non-physicians you employ, contract with, supervise and/or practice with in an office setting who provide direct patient care.

\* If you are requesting coverage with FAIRWAY, each person must complete their own Allied Healthcare Application and coverage is subject to underwriting approval and payment of premium.

21 Please indicate the number of each of the following who provide services for your practice (excluding yourself).

Nurse Midwives: \_\_\_\_\_ Nurse Practitioners: \_\_\_\_\_ Physician Surgical Assistants: \_\_\_\_\_  
Nurse Midwife Assistants: \_\_\_\_\_ Physician Assistants: \_\_\_\_\_ Other: \_\_\_\_\_ :

22 Does your practice include a surgicenter or laboratory?  Yes  No

If **Yes**, please answer the following:

- a) Where is this facility located?  On-site  Off-site
- b) Does this facility provide services solely for your patients?  Yes  No
- c) Will non-FAIRWAY insured physicians use this facility?  Yes  No

23 Do you have a full ACLS Resuscitation (crash) cart in your office?  Yes  No

If **Yes**, are you ACLS Certified?  Yes  No Expiration Date (If Applicable) MM/DD/YYYY

24 If you answer **Yes** to any of the following questions, please indicate your % of practice, provide details in the **Remarks Section** and attach any applicable, supporting documentation.

- a) Do you require coverage as a proprietor, partner, officer, director, administrator, or medical director in any medical enterprise?  Yes  No
- b) Do you provide medical services as a designated sports team physician?  Yes  No \_\_\_\_\_ %
- c) Do you provide medical services for persons in nursing homes / assisted living facilities?  Yes  No \_\_\_\_\_ %
- d) Do you provide medical services for persons in correctional facilities?  Yes  No \_\_\_\_\_ %
- e) Do you engage in telemedicine activity?  Yes  No
- f) Do you provide diagnosis via the internet or phone?  Yes  No

## Insurance Information

25 Current Carrier: \_\_\_\_\_ # of years with carrier: \_\_\_\_\_ Current Premium: \_\_\_\_\_

**If you have been with your current carrier for less than 5 years, please provide the names of your previous carrier(s) and policy term(s) in the Remarks Section.**

26 Requested Limits of Liability: \_\_\_\_\_ per claim \_\_\_\_\_ aggregate

27 If you answer **Yes** to any of the following questions, please provide details in the **Remarks Section** and attach any applicable, supporting documentation.

- a) Have you ever stopped practicing medicine for an extended period of time? (e.g. leave of absence, sabbatical, pregnancy, etc.)  Yes  No
- b) Have you ever practiced without professional liability insurance? (e.g. gap in coverage)  Yes  No
- c) Have you ever had your hospital privileges suspended, denied, restricted, placed in probationary status or revoked?  Yes  No
- d) Has any governmental agency investigated, suspended, revoked, or taken any other action against either your narcotics license or your license to practice medicine?  Yes  No
- e) Have you ever been charged with or convicted of a crime other than minor traffic violations?  Yes  No
- f) Have you ever been diagnosed, treated or voluntarily entered into treatment for alcoholism, drug addiction, chemical dependency, or a mental or chronic physical illness?  Yes  No
- g) Has any professional liability carrier ever denied, terminated, restricted, or modified your professional liability coverage? (e.g. surcharges, co-payments, or deductibles)  Yes  No  
NOTE: MISSOURI APPLICANTS DO NOT RESPOND

**Please be advised that you will have no coverage from Fairway Physicians Insurance Company for any known claims or incidents that may lead to a claim or lawsuit. All claims or incidents that may lead to a claim or lawsuit should be reported to your current malpractice insurer before terminating your existing policy (coverage for any such lawsuits, claims, or incidents is subject to the terms of your current carrier's policy).**

28 Whether or not you believe you are at fault, if you answer **Yes** to any of the questions below, you must complete the **Claims Information** section.

- a) Have you ever had a "claim" or attempted to settle a "claim" on your own behalf?  Yes  No

**DEFINITION:** For purposes of this Application a "claim" is an expression of dissatisfaction or demand for something as a right or as due **from a patient or on a patient's behalf**. A "claim" includes, but is not limited to, a letter expressing dissatisfaction, **a notice of intention to sue, a lawsuit, a counterclaim or a demand for arbitration**.

- b) Are you aware of any incidents resulting in injury or death to a patient where your professional services were utilized? (e.g. Attending Physician, Assistant, Consultative)  Yes  No
- c) Are you, your employees, or associates aware of any threats or complaints against you or your medical practice?  Yes  No
- d) Have you ever been the subject of a deposition or subpoena as a result of medical services provided by you on behalf of a patient? (other than as an expert witness, but including consultative services)  Yes  No

## Procedures & Treatments Information

29 Please indicate if you or your staff perform the following procedures:

	Physician	Non-Physician Licensed Staff	Non-Licensed Staff
Botox Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Peel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Tattooing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Wrinkle Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microdermabrasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanent Make-Up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sclerotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cosmetic Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30 Please list any procedures or treatments you perform for which you did not receive training in your residency or that are outside the customary scope of practice for your specialty.

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31 Please list any procedures or treatments that you have discontinued in the past 10 years.

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32 Do you use any non-FDA Approved Drugs, Pharmaceuticals or Medical Devices?  Yes  No

33 Do you perform any emergency room duties or work at an urgent care facility?  Yes  No

34 Please select all treatments and procedures that you perform and indicate the % of your practice where requested. Use the **Remarks Section** and attach any applicable, supporting documentation for all other procedures or treatments you perform not listed below.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abdominoplasty                         | <input type="checkbox"/> Cleft Lip/Palate Surgery   | <input type="checkbox"/> Oxidation Therapy                  |
| <input type="checkbox"/> Abortions - Elective ___ %             | <input type="checkbox"/> Colon Hydrotherapy         | <input type="checkbox"/> Ozone Therapy                      |
| <input type="checkbox"/> Abortions - Therapeutic ___ %          | <input type="checkbox"/> Colonoscopy                | <input type="checkbox"/> Pain Management                    |
| <input type="checkbox"/> Acupuncture                            | <input type="checkbox"/> Convulsive/Shock Therapy   | <input type="checkbox"/> Peritoneoscopy                     |
| <input type="checkbox"/> Allergy Treatments                     | <input type="checkbox"/> Cryosurgery                | <input type="checkbox"/> Phlebography                       |
| <input type="checkbox"/> Anesthesia - General/Spinal/Caudal     | <input type="checkbox"/> D&C                        | <input type="checkbox"/> Pneumoencephalography              |
| <input type="checkbox"/> Angiography                            | <input type="checkbox"/> Electromagnetic Therapy    | <input type="checkbox"/> Polypectomy                        |
| <input type="checkbox"/> Angioplasty                            | <input type="checkbox"/> Embolization               | <input type="checkbox"/> Prenatal Care                      |
| <input type="checkbox"/> Anti-Aging Treatments                  | <input type="checkbox"/> Endoscopy                  | <input type="checkbox"/> 1st & 2nd Trimester                |
| <input type="checkbox"/> Arteriography                          | <input type="checkbox"/> Face Lifts ___ %           | <input type="checkbox"/> to term, no delivery               |
| <input type="checkbox"/> Arthritis Treatments                   | <input type="checkbox"/> Gynecology - Major Surgery | <input type="checkbox"/> to term, and delivery              |
| <input type="checkbox"/> Arthroscopy                            | <input type="checkbox"/> Hair Transplants           | <input type="checkbox"/> Normal Deliveries - per year ___   |
| <input type="checkbox"/> Assisting in Surgery - Own Patients    | <input type="checkbox"/> Hypothyroidism             | <input type="checkbox"/> Cesarean Deliveries - per year ___ |
| <input type="checkbox"/> Assisting in Surgery - Other Patients  | <input type="checkbox"/> Intrathecal Pumps          | <input type="checkbox"/> Penial Implants                    |
| <input type="checkbox"/> Bariatric Surgery                      | <input type="checkbox"/> I.V. Therapy               | <input type="checkbox"/> Prolotherapy                       |
| <input type="checkbox"/> Bio-Identical Hormone Therapy          | <input type="checkbox"/> Kyphoplasty                | <input type="checkbox"/> Radial/Laser Keratotomy            |
| <input type="checkbox"/> Biopsy - Endoscopic                    | <input type="checkbox"/> Laparoscopy                | <input type="checkbox"/> Radiation/X-Ray Therapy            |
| <input type="checkbox"/> Blepharoplasty ___ %                   | <input type="checkbox"/> Laminectomy                | <input type="checkbox"/> Radiopaque Dye                     |
| <input type="checkbox"/> Brachioplasty                          | <input type="checkbox"/> Laser Surgery              | <input type="checkbox"/> Rheumatology                       |
| <input type="checkbox"/> Breast Implants - Cosmetic ___ %       | <input type="checkbox"/> Laser Therapy              | <input type="checkbox"/> Rhinoplasty ___ %                  |
| <input type="checkbox"/> Breast Implants - Reconstruction ___ % | <input type="checkbox"/> Lipoinjection ___ %        | <input type="checkbox"/> Sigmoidoscopy                      |
| <input type="checkbox"/> Breast Reduction ___ %                 | <input type="checkbox"/> Liposuction ___ %          | <input type="checkbox"/> Silicone Injections ___ %          |
| <input type="checkbox"/> Bronchoscopy                           | <input type="checkbox"/> Lithotripsy                | <input type="checkbox"/> Skin Flaps/Grafts ___ %            |
| <input type="checkbox"/> Bronco-esophagology                    | <input type="checkbox"/> Lymphangiography           | <input type="checkbox"/> Spinal Cord Stimulators            |
| <input type="checkbox"/> Candidiasis                            | <input type="checkbox"/> Mammograms                 | <input type="checkbox"/> Thermography                       |
| <input type="checkbox"/> Cataract Surgery                       | <input type="checkbox"/> Myelography                | <input type="checkbox"/> Tubal Ligations                    |
| <input type="checkbox"/> Catheterization                        | <input type="checkbox"/> Nerve Blocks               | <input type="checkbox"/> U.V. Light Blood Irradiation       |
| <input type="checkbox"/> Chelation Therapy                      | <input type="checkbox"/> Neural Therapy             | <input type="checkbox"/> Vasectomies                        |
| <input type="checkbox"/> Chemical Sensitivity                   | <input type="checkbox"/> Other Implants             | <input type="checkbox"/> Vertebroplasty                     |
|   |   | <input type="checkbox"/> Weight Control Medication          |

**Claims Information**

Please copy this page for all additional claims you are reporting to FAIRWAY.

**NOTE:** This **Claims Information Form** pertains to lawsuits, claims or demands for arbitration or incidents which could lead to claims. A claims form must be completed for each lawsuit, claim, demand for arbitration or incident. Sufficient information must be provided to evaluate medical aspects of the case specifically relating to the physician's involvement.

1 Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

2 Your relationship to the patient (i.e. Attending Physician, Primary Physician)

3 Date of Incident: MM/DD/YYYY Date Reported: MM/DD/YYYY Location: \_\_\_\_\_

4 Insurance Carrier: \_\_\_\_\_ Other Defendants: \_\_\_\_\_

5 Present Status:  Open  Closed MM/DD/YYYY

Incident Only  90-Day Notice  Suit Filed  Suit Served  Arbitration

Method of Closing:  Dismissed  Defense Verdict

Settled: Amount Paid On Your Behalf: \_\_\_\_\_ Total Settlement: \_\_\_\_\_

Judgment: Amount Paid On Your Behalf: \_\_\_\_\_ Total Settlement: \_\_\_\_\_

6 The following questions should be answered in explicit, clinical detail to allow proper evaluation by the Fairway Underwriting Department. Attach additional sheets as required.

a) Patient's allegations or circumstances brought to your attention:

\_\_\_\_\_  
\_\_\_\_\_

b) Dates and description of treatment rendered:

\_\_\_\_\_  
\_\_\_\_\_

c) Condition of patient subsequent to treatment (and dates of follow-up treatment):

\_\_\_\_\_  
\_\_\_\_\_

7 I understand information submitted herein becomes part of the FAIRWAY's Named Insured's records.

Date: MM/DD/YYYY

Physician Name (Printed): \_\_\_\_\_

Physician Signature: \_\_\_\_\_



**APPLICANT RETROACTIVE COVERAGE**

**The following statements refer to your application for retroactive coverage with Fairway Physicians Insurance Company, A Risk Retention Group (“FAIRWAY”).**

If you are approved for retroactive coverage, you will receive a certificate of coverage with a specified retroactive coverage date. Thereafter and subject to the terms, conditions and exclusions of the Fairway Physicians Insurance Company policy, you will be entitled to claims defense and claims payment services described in your policy with FAIRWAY for any unknown incidents that may lead to a claim or lawsuit arising out of incidents subsequent to the retroactive date indicated in your certificate of insurance with FAIRWAY.

Retroactive coverage is only available from FAIRWAY to those physicians who have maintained continuous and uninterrupted “Claims-Made” medical professional liability coverage up to the commencement date of their coverage with FAIRWAY.

**OBLIGATION OF DISCLOSURE**

We require you to disclose to Fairway Physicians Insurance Company (“FAIRWAY”) any information known to you that would influence FAIRWAY’s decision to approve your application for coverage, including the information you provided in this claims section. You also have an obligation to inform FAIRWAY of any information that becomes known to you between the date of your signature below and the effective date of coverage with FAIRWAY that could alter your previous response to the claims information requested herein. You are advised to notify FAIRWAY of any additional information not previously disclosed in your application for coverage.

**YES**, I request retroactive coverage from FAIRWAY for any unknown incidents that may lead to a claim or lawsuit arising out of incidents and subsequent to my retroactive coverage date with FAIRWAY.

I represent and warrant that I will maintain my current professional liability coverage up to the commencement date of my membership with Fairway Physicians Insurance Company. I make this representation with the understanding that should any future investigation reveal that I did not maintain continuous claims-made professional liability coverage, FAIRWAY may deny all claims defense and claims payment services for any claim arising out of professional services that I rendered to patients during the retroactive coverage period.

I also make this representation with the understanding that my failure to meet my obligation of disclosure may result in the termination of my policy with FAIRWAY and the loss of all claims defense and claims payments services.

**Requested Retroactive Date:** MM/DD/YYYY

**NO**, I decline retroactive coverage from FAIRWAY.

**This application for Retroactive Coverage is deemed part of your Application for Membership in FAIRWAY and is incorporated by this reference into the FAIRWAY policy.**

I declare under penalty of perjury that the foregoing is true and correct. Executed this Day of Month, Year in City, State, by Signature

**DISCLOSURES**

**Representations and Warranties:** I hereby warrant the truth of all statements and answers contained in this application. I have not withheld any facts about my professional practice which are reasonably calculated to or may influence the judgment of Fairway Physicians Insurance Company in considering this application. I understand that if I have withheld any material facts concerning the risk exposure of my professional practice and FAIRWAY is made aware of my lack of disclosure, I will have no coverage for any claims that may arise due to my lack of disclosure and my coverage with FAIRWAY may be declined. I agree to notify FAIRWAY in a timely manner of any change to my practice or to the information regarding an open claim or incident as it becomes available to me. I acknowledge that coverage through FAIRWAY is governed by the terms of my FAIRWAY policy. I agree that upon FAIRWAY's acceptance of my application, my execution of the insurance agreement and the initiation of payments of my insurance premium, I will be deemed to have professional liability coverage by Fairway Physicians Insurance Company. I understand that my execution of this application does not bind FAIRWAY to admit me as a member in FAIRWAY, nor does it bind me to become a member of FAIRWAY, if accepted. In addition, I understand and agree that I have no right to receive any information regarding the basis or reasons by FAIRWAY concerning my application for coverage. I further understand that my membership and my professional liability coverage does not become effective until my application has been accepted by FAIRWAY and payments for coverage have been received.

**References:** I authorize and direct any individual, government agency, medical society, physician, hospital, insurance agent or company representative to furnish information concerning me or my medical practice which FAIRWAY may require. This authority extends to the release of information regarding professional liability coverage and claims. I also agree that any person or organization, together with the officer, directors and agents, will not be liable in any way for furnishing such information even though the information may be incomplete or incorrect.

Should I employ the services of an insurance broker/consultant through FAIRWAY to assist me in securing professional liability coverage, I hereby authorize FAIRWAY to release any and all necessary information to such individuals or agency/organizations.

Name of Applicant (Please Print): \_\_\_\_\_

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

Date: MM/DD/YYYY