



**III. PHYSICIAN UNDERWRITING INFORMATION**

1. If your answer to any of the following is "Yes," give details on a separate signed and dated sheet of paper. **If your answer to "e" and/or "f" is "Yes" it is also necessary to complete the Underwriting Claim Investigation form for each claim.**

- a. Has your license to practice medicine in any state or country or your permit to prescribe drugs ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation?  Yes  No
- b. Have you ever been or are you currently under a Consent Order or agreement with any state licensing board of medical examiners, DEA, or governmental agency (public or private)? If "Yes", attach a copy of the applicable documents.  Yes  No
- c. Have you ever been convicted of a criminal offense or are you under investigation for a criminal offense?  Yes  No
- d. Have you been treated or evaluated for alcoholism, narcotics or other substance abuse, sexual addiction/misconduct, anger management issues or any other mental illness? (Provide dates and locations of all treatments or evaluations, and the names of your supervising and monitoring physicians.)  Yes  No
- e. Have you received psychiatric/psychological treatment or evaluation during the last 3 years (other than in the course of your training or in family/marital counseling)?  Yes  No
- f. Have you become aware of any illness or physical defect, or have you received any major medical/surgical treatment or evaluation in the last 3 years?  Yes  No
- g. Do you enter into any oral or written contract or agreement guaranteeing the result of any treatment or operation performed by you, personally, or performed under your supervision?  Yes  No
- h. Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy?  Yes  No
- i. Has your involvement in any health program (e.g. Medicare, Medicaid, HMOs, PPOs, or other managed care provider) ever been suspended, placed on probation, terminated, or limited in any way?  Yes  No

2. Do you perform any surgical procedures?  Yes  No If "Yes", check ( ) all surgical/medical procedures you perform and enter the appropriate number you perform each month where indicated:

___ Abdominal surgery _____ per mo. ___ Abortions _____ per mo. ___ Where: _____ ___ Trimester: _____ ___ Acupuncture _____ per mo. ___ Adenoidectomies _____ per mo. ___ Amniocentesis ___ Angiography ___ Venous _____ per mo. ___ Arterial ___ Peripheral angioplasty ___ Angioplasty _____ per mo. ___ Appendectomies _____ per mo. ___ Aspirations ___ Assistance in major surgery ___ On own or group's patients only ___ On patients of others ___ Back/spinal surgery _____ per mo. ___ Bariatric surgery _____ per mo. ___ Cosmetic ___ Medical necessity ___ Breast implants _____ ___ Cardiac catheterization ___ Diagnostic coronary angiography ___ Left heart catheterization ___ Permanent pacemaker ___ PTCA (coronary angioplasty) ___ Cardiac surgery _____ per mo.	___ Cast (set) ___ Cholecystectomies _____ per mo. ___ Circumcisions (other than newborn) ___ Closed reductions of fracture _____ per mo. ___ Colonoscopies/sigmoidoscopies ___ Cryosurgery on malignant lesions ___ Cosmetic surgery (elective) _____ per mo. Detail each type and number per type _____ _____ ___ Cranial surgery _____ per mo. ___ CT scanning ___ no dye ___ with dye ___ C-sections _____ per mo. ___ Deliveries _____ per mo. ___ Dilation and curettage _____ per mo. ___ Diskography ___ EGD ___ EKG ___ Endoscopies _____ per mo. ___ ERCP ___ Flexible sigmoidoscopies ___ Fluoroscopic procedures ___ Hemorrhoidectomies ___ Herniorrhaphies _____ per mo. ___ Hysterectomies _____ per mo.	___ Image guided Biopsy _____ per mo. ___ Injection of irradiated substances into the blood stream for diagnostic purposes (IVPs) ___ Laminectomies _____ per mo. ___ Laparoscopic cholecystectomies _____ per mo. ___ Laparoscopic laser surgery ___ per mo. ___ Laparoscopy (peritoneoscopy) ___ Large Core Needle Biopsy ___ Liposuction _____ per mo. ___ type _____ ___ area(s) of body _____ ___ Lumbar puncture ___ Lymphangiography ___ Mammography _____ per mo. ___ Myelography ___ Neo-natal intensive care visits ___ Phlebography ___ Open reductions _____ per mo. ___ Orthopedic surgery _____ per mo. ___ Pneumatic or mechanical esophageal dilation ___ With Bougie or olive clip ___ Without Bougie or olive clip ___ Pneumoencephalography ___ Pre-natal care past first trimester	___ Radiation therapy ___ Radiopaque dye injection (other than IVP) in the blood vessels, lymphatics, sinus tracts and fistulae ___ Shock therapy (ECT/EST) ___ Thoracic surgery _____ per mo. ___ Thrombolytic Therapy ___ Tonsillectomies _____ per mo. ___ Trauma surgery _____ per mo. ___ Tubal ligations ___ Tumor Ablation ___ Uterine Fibroid embolization ___ Vascular surgery _____ per mo. ___ Vasectomies ___ Venipunctures ___ Vertebroplasty _____ per mo. ___ Other surgeries/no. _____ per mo. _____ _____ ___ List of endoscopies performed _____ _____ ___ Administer or supervise anesthesia ___ Other _____ _____ _____
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3. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunication, video, or information systems?  Yes  No If so, please describe: \_\_\_\_\_

4. Are you part-time/semi-retired?  Yes  No If Yes, please request a part-time/semi-retired application.

5. a. Are you engaged in any "moonlighting" activities?  Yes  No

If "Yes", number of hours per month: \_\_\_\_\_ Organization: \_\_\_\_\_

Please describe such activities: \_\_\_\_\_

Will you maintain professional liability insurance with other insurance companies for moonlighting activities?  Yes  No

If "Yes", name of insurance carrier (enclose copy of Introduction Page or Declaration Page): \_\_\_\_\_

b. Do you provide medical professional services to correctional institutions? (i.e. Federal or State Prisons, county Jails or Youth Detention Centers)

Provide percentage of practice and correctional institutions location \_\_\_\_\_

6. Please estimate the ANNUAL numbers of the following professional services you provide as an individual. (Do not use total figures for your group)

a. Patient encounters (including office visits, x-rays, anesthesia, etc.): \_\_\_\_\_

b. Hospital inpatient admissions: \_\_\_\_\_

c. Hospital surgical procedures: \_\_\_\_\_

d. Outpatient Surgical procedures: \_\_\_\_\_

e. Patients seen in emergency room: \_\_\_\_\_

7. **Have your hospital staff privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered or in any other way restricted, or have been or are they currently under investigation?**  Yes  No

8. a. List all hospitals and surgical centers where you currently have staff privileges or have applied for staff privileges and % of practice at each:

Name	City/State	JCAHO Approved	Applied	Active	Courtesy	% of Practice

b. Do you provide any call coverage for physicians outside of your practice specialty?  Yes  No

If "Yes", please explain: \_\_\_\_\_

c. If you do not have admitting privileges, please describe in detail your procedure for handling your patients who may require in- patient care:

\_\_\_\_\_

**IV. BUSINESS INFORMATION**

1. Have you formed any new organizations (if "No", skip to Question Number 7)?  Yes  No

2. What is the name of the organization? \_\_\_\_\_

3. What is the date of the formation of the new organization? \_\_\_\_\_

4. What is the primary business of new organization? \_\_\_\_\_

5. Are all physicians associated with this new organization insured with MAG Mutual?  Yes  No

If "No", please explain: \_\_\_\_\_

6. Do you want this new organization to share in your current organization's limit?  Yes  No

If "No", please explain: \_\_\_\_\_

7. Do you employ and/or provide supervision for any allied healthcare professionals?  Yes  No

If "Yes", please include name of each, license number of each, date employed, and insurer of each, in the spaces provided below.

	Name	License #	Date Employed	Insurer
Anesthetic Asst. (CRNA, PA or AA)	_____	_____	_____	_____
	_____	_____	_____	_____
Nurse Midwife (CNM)	_____	_____	_____	_____
	_____	_____	_____	_____
Nurse Practitioner (NP)/ Physician's Asst. (PA)	_____	_____	_____	_____
	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____
Optometrist (OD)	_____	_____	_____	_____
Podiatrist	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
Social Worker	_____	_____	_____	_____

8. Do you want to provide coverage for any of the above listed employees with the policy that may be issued from this Renewal Application?  Yes  No

If "Yes": a. Do you want a separate limit for them? If so, please provide copy of their current Declarations Page and date of birth.

Are they full or part-time employees? \_\_\_\_\_ Explain: \_\_\_\_\_

OR b. Do you want them to share in your limits or the limits of the organization (if organization has separate limit)? My limits \_\_\_\_\_ Organizational limit \_\_\_\_\_

9. Do you supervise any non-employed allied healthcare professionals other than those already listed above? If yes, please explain:

10. Other products and services available through MAG Mutual (please check (✓) those you would like more information on):

- |  |  |
|--|--|
| <input type="checkbox"/> Workers' Compensation Insurance                     | <input type="checkbox"/> Personal or Group Health Insurance                  |
| <input type="checkbox"/> Businessowners Insurance                            | <input type="checkbox"/> Billing or Transcription Services                   |
| <input type="checkbox"/> Employment Practices Liability Insurance            | <input type="checkbox"/> Accounting and Tax Services                         |
| <input type="checkbox"/> Regulatory Fraud and Abuse Insurance and Consulting | <input type="checkbox"/> Pension Planning, Establishing or Managing Your IRA |
| <input type="checkbox"/> Healthcare Services Facility Insurance              | <input type="checkbox"/> Disability Income Protection, Life Insurance        |
| <input type="checkbox"/> Auto, Home and Personal Liability Insurance         | <input type="checkbox"/> Financial   |

Policy Number: \_\_\_\_\_

MAG Mutual Insurance Company

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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states and may subject the person to criminal and civil penalties.

**FLORIDA** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Fla. Stat. § 817.234(1)(b).

**KENTUCKY** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. KRS § 304.47-030.

**TENNESSEE and VIRGINIA** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Tenn. Code Ann. § 56-53-111(b)(1)(A). Va. Code Ann. § 52-40 (2009).

IT IS NECESSARY FOR ALL APPLICANTS TO SIGN SPACES BELOW.

**IMPORTANT:** Incomplete or incorrect information could result in a retroactive upward premium adjustment, or could lead to a denial of coverage in the event of a claim.

I hereby declare that the statements and responses I have provided in this application are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that deliberate misstatements, which are deemed material or fraudulent, may be grounds for cancellation or denial of coverage in the event of a claim.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I understand that this is an application for insurance and not an insurance binder. I also understand that, if my application is approved, my effective date cannot be prior to the date that I have met all of the Company's requirements for issuance.

X \_\_\_\_\_  
Applicant's Signature (required) Date

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance with the Company (MAG Mutual Insurance Company and Professional Security Insurance Company) hereby authorizes his/her present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request all non-privileged information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney or the Company may have a bearing upon his/her acceptability to the Company as a professional liability risk.

The undersigned also authorizes all medical associations, medical societies and managed care organizations in which he/she is or has been a member, all hospitals in which he/she now holds or has held staff privileges, the state board of medical examiners for the state in which he/she has practiced, the state department of public health for the state in which he/she has practiced or resided, motor vehicle departments, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which, in the judgment of any such person or entity, has a bearing upon his/her acceptability to the Company as a professional liability risk. The undersigned hereby agrees to hold harmless from and against any and all claims, demands and causes of action against any person or entity who releases information on his/her behalf according to this authorization. Furthermore, the undersigned agrees to hold harmless to the same extent the Company and any of its present or former employees and agents. **The undersigned acknowledges that this application may be used by the Company to underwrite coverage with MAG Mutual Insurance Company and/or Professional Security Insurance Company. Applications for Professional Security Insurance Company may be submitted only through a licensed, surplus lines broker or agent as Professional Security Insurance Company is an unauthorized insurer eligible to transact insurance in your state under applicable surplus lines insurance laws.**

X \_\_\_\_\_  
Applicant's Signature (required)

By signing in the space below, you also authorize the Company or its duly authorized agents to provide a CERTIFICATE OF INSURANCE to interested parties.

X \_\_\_\_\_  
Applicant's Signature (optional) Date

X \_\_\_\_\_  
Agent's Name Agent's Licensing Number