tmic

TEXAS MEDICAL INSURANCE COMPANY

ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION

- ❑ **Applicant must be employed and supervised by a TMLT insured physician.**
- ❑ Complete and sign the *Application for Coverage*.
- ❑ Complete the *Claim/Suit Information Addendum* if a professional liability claim or suit has **ever** been brought against you.
- ❑ Copy of certificate or licensure.
- ❑ **IMPORTANT! Attach a copy of your *Declarations Page* and all other pages relative to the retroactive or prior acts date of your current insurance.**
- ❑ If payment is included make your check payable to *Texas Medical Insurance Company* or *TMIC*.
- ❑ Return all applicable forms to:
  P.O. Box 160140
  Austin, TX 78716-0140
  We encourage the return of multiple applications for one company in the same envelope.
- ❑ Include a listing of all applicants by name and profession.

Instructions regarding premium payment:
Quarterly and annual payment options will be billed by invoice and mailed to the *Named Insured*. If you choose the monthly payment option, you must complete, sign and return the enclosed *Authorization for Direct Bank Debit* along with a voided check on the account to be debited.

If you have any questions, we will be happy to assist you. Call our toll free number listed below and ask for Sales.

TEXAS MEDICAL INSURANCE COMPANY
P.O. Box 160140 • Austin, TX 78716-0140
901 Mopac Expressway South • Barton Oaks Plaza V, Suite 500 • Austin, TX 78746
Toll free: 800-580-8658 • Local: 512-425-5800 • Fax: 512-425-5998
Email: sales@tmic.biz • www.tmic.biz

Receipt by TMIC of application(s) and/or premium payment does not constitute a binder or acceptance of coverage.

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P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmic.biz

INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

PLEASE TYPE OR PRINT IN BLACK INK.
ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

POLICY NUMBER_____
(For Office Use Only)

I. GENERAL INFORMATION

First Name of Applicant | Middle Name | Last Name

Home Address | City | State | Zip Code

Date of Birth | #_____ Texas Medical License/Status (please provide copy) | #_____ Social Security Number

Office Phone: Area Code Number | Home Phone: Area Code Number | Fax: Area Code Number

Pager: Area Code Number | Cell Phone: Area Code Number | Email Address

Name of Policy Owner (**Who will own/pay for this policy?**)

Principal Office Address Number Street | Suite | City | State | Zip Code | County

II. PRACTICE DESCRIPTION

A. Are you a (please check one):

❑ Dental Hygienist	❑ Nurse Midwife	❑ Pharmacist	❑ Surgical Assistant	❑ Other
❑ EMT/Paramedic	❑ Nurse Practitioner	❑ Physician Assistant	❑ Technician	_____
❑ LVN	❑ Optician	❑ Psychologist	❑ Technologist	_____
❑ Nurse Anesthetist	❑ Optometrist	❑ RN	❑ Therapist	_____

B. Are you a/an (please check one):

1. ❑ Employee ❑ Independent Contractor ❑ Practice Owner ❑ Other _____
2. Name of employer:
   _____
3. Name of practice:
   _____
4. Name of supervising physician, if applicable:
   _____

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III. INSURANCE COVERAGE

A. Does your employer have professional liability insurance? Yes ❑ No ❑

Insurance Company: _____ Limits of liability: _____

B. Requested coverage effective date 12:01 a.m. _____/_____/_____
Month Day Year

In no event shall the effective date of the policy, if issued, be earlier than the date TMIC receives this application.

C. Professional Liability Coverage Please check type of coverage (**Occurrence or Claims-made**) and the limits of liability desired. (Note: Occurrence coverage is not available to a Physician Assistant, Nurse Anesthetist, Nurse Midwife or EMT/Paramedic)

❑ **Occurrence** (Limits indicated are the only limits available and are for Each Claim and All Claims)
❑ $100,000/$300,000 ❑ $200,000/$600,000

OR

❑ **Claims-made** (Limits indicated are Each Claim and All Claims)
❑ $100,000/$300,000 ❑ $200,000/$600,000 ❑ $500,000/$1,500,000

D. Insurance History for Previous Three Years

	Current Year	First Prior Year	Second Prior Year
1. Insurance Company:			
Coverage Form:	❑ Claims-made ❑ Occurrence	❑ Claims-made ❑ Occurrence	❑ Claims-made ❑ Occurrence
Policy Period:			
Limits of Liability Per Claim/All Claims:			

If your current insurance is written on a Claims-made form, it is necessary to purchase a Reporting Endorsement (tail coverage) from your present insurer or Prior Acts (nose coverage) from TMIC to reduce the chances of having a gap in coverage.

2. Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer for all your previous exposures? Yes ❑ No ❑

If no, are you requesting Prior Acts (nose coverage) from TMIC? Yes ❑ No ❑

IV. PRIOR ACTS COVERAGE

If you are not requesting Claims-made coverage, including Prior Acts, from TMIC, skip to Section V.

A. Has any portion of your practice been performed outside the state of Texas? Yes ❑ No ❑
If yes, please list below the states, dates and the percentage of practice for each year.

_____

_____

B. Are you aware of any incidents (patient expressions of dissatisfaction or fee disputes resulting from treatment rendered) which you have reason to believe may lead to a claim or suit against you? Yes ❑ No ❑

C. Have you reported any incidents (which have not yet resulted in a claim or suit) to another insurance carrier? Yes ❑ No ❑

D. Have you received any oral or written threats of legal action, attorney's request for patient records, subpoena, petition, or other legal process or notification? Yes ❑ No ❑

If you answered yes to B, C, or D above, you must provide details below. Report all incidents identified under B or D to your current insurance carrier. Doing so does not necessarily eliminate the need for the Reporting Endorsement (tail coverage).

Patient Name	Date of Incident	Date incident report sent to insurance carrier (provide copies)

V. UNDERWRITING AND RATING INFORMATION

A. Medical Practice History

1. Professional Education/Training

SCHOOL/HOSPITAL	CITY/STATE	DATES	DEGREE/CERTIFICATIONS

2. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.)

_____ From_____/_____To_____/_____
Physician/Employer City State Country Month Year Month Year

_____ From_____/_____To_____/_____
Physician/Employer City State Country Month Year Month Year

_____ From_____/_____To_____/_____
Physician/Employer City State Country Month Year Month Year

V. UNDERWRITING AND RATING INFORMATION

B. Practice Information

1. On average, how many hours per week do you work?_____

2. Does your employment/practice require that you ever be in an operating room? Yes ❑ No ❑

3. Does your employment/practice include work in an emergency room? Yes ❑ No ❑

4. Does your employment/practice include prenatal care? Yes ❑ No ❑

5. Does your employment/practice require that you ever be in a labor and delivery room? Yes ❑ No ❑

Note: If you are employed or practice as a Nurse Midwife performing deliveries, please complete the *Nurse Midwife Supplemental Application.*

6. Do you: Employ ❑ Supervise ❑ Contract ❑ with any health care professionals? Yes ❑ No ❑

Name	Profession	Insured By	Limits of Liability
Name	Profession	Insured By	Limits of Liability

7. Briefly describe your general duties:

_____

_____

_____

8. Describe the extent to which you are supervised and by whom:

_____

_____

_____

9. Number of years employed in your current profession:_____

Note: If you answer "yes" to questions 10-18, please provide details on page 6.

V. UNDERWRITING AND RATING INFORMATION

10. Has your license, certification or permit ever been denied, restricted, revoked, suspended, cancelled or voluntarily surrendered? Yes ❑ No ❑

11. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? Yes ❑ No ❑

12. (a) Has any hospital or clinic ever denied, restricted, suspended, or revoked your privileges? Yes ❑ No ❑
    (b) Are you currently under investigation? Yes ❑ No ❑
    (c) Have you ever resigned from a hospital, clinic, or other facility during or following a medical staff investigation? Yes ❑ No ❑

13. Has your membership in any professional society or association ever been denied, cancelled, revoked, or censured? Yes ❑ No ❑

14. Have you ever been treated for alcoholism or substance abuse? Yes ❑ No ❑
    If yes, provide details and a recent statement of insurability from your treating physician.

15. Have you now or ever had any chronic illness, mental illness or physical impairment? Yes ❑ No ❑
    If yes, provide details and a recent statement of insurability from your treating physician.

16. Have you ever been indicted, charged or convicted of a crime other than a minor traffic violation? Yes ❑ No ❑

17. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled or non-renewed? Yes ❑ No ❑
    If yes, please explain why, when and name of insurer(s).

18. Are you aware that your present insurer plans to restrict, surcharge, cancel or non-renew your coverage? Yes ❑ No ❑

19. How many professional liability claims have **ever** been brought against you? #_____
    This includes notice of intent to sue, written demand from a patient or lawsuit.
    Complete the information for all claims/suits on page 7.

VI. AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any policy is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding.

All potential claims or lawsuits have been disclosed herein and have been reported to the applicable, prior professional liability insurance carrier. **I understand any policy issued by TMIC will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMIC any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: any licensing agency; any medical association or society; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability. I further authorize TMIC and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

By submission of this application, or by acceptance of coverage from TMIC, I hereby release TMIC and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

Applicant's Signature _____ Date Signed _____

Policy Owner's Signature _____ Date Signed _____

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE
Coverage will not be considered until this application is completed, signed and dated.
Failure to provide complete information/attachments as requested will cause delay.

ENCLOSE a copy of your current Professional Liability **Declarations Page** and **license.**

VII. ADDITIONAL INFORMATION

Please use this area if additional space is needed for answers to any questions.

PAGE NUMBER	QUESTION NUMBER	ANSWER AND/OR DETAILS

VIII. CLAIM/SUIT INFORMATION ADDENDUM

1. CLAIM/SUIT INFORMATION

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month/Day/Year

Insurance company defending your claim: _____

Location: City _____ State _____ Hospital _____

Procedures performed: _____

ALLEGATIONS and narrative description of the medical facts and your involvement. Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Claim settled without indemnity payment on your behalf? Yes ❑ No ❑

Claim is pending: Yes ❑ No ❑

Suit filed: Yes ❑ No ❑ If Yes: Month _____ Year _____

Court Trial: Yes ❑ No ❑ Jury verdict: Yes ❑ No ❑

Settlement out of court: Yes ❑ No ❑ If Yes: Month _____ Year _____

Total amount paid to claimant on **your** behalf: $_____

Total amount paid to claimant for **all** defendants: $_____

2. CLAIM/SUIT INFORMATION

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month/Day/Year

Insurance company defending your claim: _____

Location: City _____ State _____ Hospital _____

Procedures performed: _____

ALLEGATIONS and narrative description of the medical facts and your involvement. Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Claim settled without indemnity payment on your behalf? Yes ❑ No ❑

Claim is pending: Yes ❑ No ❑

Suit filed: Yes ❑ No ❑ If Yes: Month _____ Year _____

Court Trial: Yes ❑ No ❑ Jury verdict: Yes ❑ No ❑

Settlement out of court: Yes ❑ No ❑ If Yes: Month _____ Year _____

Total amount paid to claimant on **your** behalf: $_____

Total amount paid to claimant for **all** defendants: $_____