



FAIRWAY PHYSICIANS INSURANCE COMPANY

A RISK RETENTION GROUP

APPLICATION INSTRUCTIONS

PHYSICIANS & SURGEONS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE (Including Integrative Medicine)

In order to hasten your request for coverage and avoid any unnecessary delay, please complete all questions. If a question does not apply to your specialty, mark "None" or "N/A" (Not Applicable). Do not leave any question unanswered! Please use separate paper for any additional comments, explanation or clarification if necessary.

Before submitting your application, please review this checklist to ensure the information below has been included. Missing information could delay the approval of your application.

- ☐ Sign, initial and date the application where indicated. The company will not issue quotes for unsigned applications.**
- ☐ Include a copy of your current Curriculum Vitae (CV).**
- ☐ Include a copy of your most recent professional liability declaration page and claims history with retroactive date.**
- ☐ Complete the "Remarks" section for any questions requiring additional details.**
- ☐ If you have completed a residency or fellowship within the past year, provide two references from your training program, including one from your chief of service.**

If you need assistance with the application, please call (818) 889-7399 and ask to speak with a medical liability specialist.

NOTICE

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



PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS FOR PROFESSIONAL LIABILITY INSURANCE (CLAIMS MADE BASIS)

APPLICANT INSTRUCTIONS:

1. Indicate your requested effective date of coverage: ____ / ____ / ____
2. Please type or print.
3. Answer all questions. If the answer requires detail, please attach a separate sheet.
4. Application must be signed and dated by owner, partner or officer.
5. Please complete application at least **45 days** before the proposed effective date.
6. Please carefully read the statements at the end of this application.

I. PERSONAL AND PROFESSIONAL INFORMATION

1. Name _____ M.D.
 D.O.
LAST FIRST MIDDLE
 Other Names Used _____

2. Home Address _____
 Home Phone () Home Fax ()
STREET ADDRESS CITY STATE ZIP

3. Primary Office _____
 Business Phone () Business Fax ()
STREET ADDRESS CITY STATE ZIP
 Cell () Pager () Back Office ()

4. Date of Birth ____ / ____ / ____ 5. Social Security # ____ - ____ - ____ 6. Employer IRS # _____

7. Medical License # _____ 8. E-Mail _____

9. Website Address _____

10. Office Locations (Please list primary location above under # 3 and any secondary offices below)

a. _____
STREET ADDRESS CITY STATE ZIP % OF PRACTICE

b. _____
STREET ADDRESS CITY STATE ZIP % OF PRACTICE

II. SPECIALTY INFORMATION

1. Medical Specialty _____ % Of Practice _____

Are you requesting professional liability coverage for this specialty? YES NO

ABMS Certified? YES NO

Board Eligible? YES NO

If Board Eligible, when do you plan to take your exams? ORAL ____ / ____ / ____ WRITTEN ____ / ____ / ____
MM DD YY MM DD YY

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IV. PRACTICE HISTORY (CONTINUED)

c. SOLO EMPLOYEE GROUP

_____ / _____ /
 GROUP/PRACTICE NAME CITY STATE FROM (MM / YYYY) TO (MM / YYYY)

d. SOLO EMPLOYEE GROUP

_____ / _____ /
 GROUP/PRACTICE NAME CITY STATE FROM (MM / YYYY) TO (MM / YYYY)

2. Hospitals where you practice (Please list principal locations first)

a. _____
 HOSPITAL ADDRESS CITY STATE ZIP

b. _____
 HOSPITAL ADDRESS CITY STATE ZIP

c. _____
 HOSPITAL ADDRESS CITY STATE ZIP

3. Please explain all gaps in practice: _____

4. List all previous professional liability carriers for the last 5 years, beginning with your current carrier first.
 If none, state 'None.'

INSURANCE CARRIER	LIMITS OF LIABILITY (i.e. \$1M/\$3M)	PREMIUM	POLICY PERIOD	
			FROM	TO
	/	\$	/ /	/ /
	/	\$	/ /	/ /
	/	\$	/ /	/ /
	/	\$	/ /	/ /

5. Please explain all gaps in coverage greater than 60 days (use a separate sheet if necessary): _____

V. PROFESSIONAL HISTORY

1. Have you ever had your hospital privileges suspended, denied, restricted, placed in probationary status or revoked? YES NO

(If Yes, please explain on a separate sheet)

2. 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

(If Yes, please provide copies of complaint and disposition documents)

3. Have you ever been charged with or convicted of a crime other than minor traffic violations? YES NO

(If Yes, please explain on a separate sheet)

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION**V. PROFESSIONAL HISTORY (CONTINUED)**

4. 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

(If Yes, please explain on a separate sheet)

5. Has any professional liability carrier ever terminated, restricted or modified your coverage (e.g. Applied surcharges, co-payments or deductibles) or denied you professional liability coverage? YES NO

(If Yes, please explain on a separate sheet)

6. Does your entity include a surgicenter, laboratory or other freestanding facility? YES NO

If Yes:

Does the laboratory provide services solely for your patients? YES NO

Will non-Fairway Insured Physicians use this facility? YES NO

Do you want Fairway to insure your partnership or corporation? YES NO

(If *Not Limited* to your patients, please explain on a separate sheet)

VI. TYPE OF PRACTICE

1. Please list the names of all physicians with whom you practice in an office setting:

With whom do you share call? _____

2. Indicate your practice type:

- INDIVIDUAL SOLO/PROPRIETOR USING A DBA
- PARTNERSHIP* OFFICE SHARING ARRANGEMENT
- EMPLOYEE MEMBER OF A MULTIPERSON CORPORATION OR ASSOCIATION*
- CORPORATION*

Complete the following if your practice is:

	NAME OF ENTITY	FICTITIOUS NAME (DBA)
<input type="checkbox"/> AN OFFICE SHARING ARRANGEMENT	_____	_____
<input type="checkbox"/> A PARTNERSHIP	_____	_____
<input type="checkbox"/> A CORPORATION	_____	_____
<input type="checkbox"/> SOLO PRACTICE / OWNER USING A DBA	_____	_____

With whom do you share call? _____

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION**VI. TYPE OF PRACTICE (CONTINUED)**

3. List the names of all partners, shareholders, independent contractors or employees, and associates who provide medical care and do not have Fairway coverage.

4. State formal business/fictitious names of your partnership, association or corporation.

5. Do you employ, contract with or supervise any physicians or surgeons? YES NO

If Yes, please enter information below and attach current certificate(s) of insurance:

NAME	MEDICAL SPECIALTY	LIMITS OF LIABILITY	INSURER

VII. PRACTICE INFORMATION

1. Do you employ, contract with or supervise any allied health care professionals? YES NO
(i.e. Nurse Practitioner, Nurse Midwife, CRNA)

If Yes, please indicate below:

2. Please indicate the total number of hours worked per week: _____

3. How many patient visits per week? _____

4. Do you provide medical services as a designated sports team physician? YES NO

If Yes, please check all that apply:

HIGH SCHOOL COLLEGE PROFESSIONAL OTHER: _____

Name and Location of team(s)? _____

5. Do you require coverage as a proprietor, partner, officer, director, administrator or medical director in any medical enterprise? YES NO

If Yes, describe percentage of your practice and name(s) of medical enterprise:

6. Do you engage in telemedicine activity? YES NO

(If Yes, please explain on a separate sheet)

7. Do you prescribe drugs or provide diagnosis via the internet? YES NO

(If Yes, please explain on a separate sheet)

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

VIII. OFFICE SURGERY

1. Do you have a full ACLS Resuscitation (crash) cart in your office? YES NO
2. Are you ACLS Certified? YES NO
- If Yes, Expiration Date: _____ / _____ / _____
3. Do you have an accredited surgicenter in your office? YES NO

IX. APPLICANT CLAIMS HISTORY

DEFINITION: A claim is a demand for money from a patient or on a patient's behalf, a 90-day notice of intention to sue, a lawsuit, a counterclaim or a demand for arbitration.

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).

1. Have you ever been or are you now involved in any professional liability (malpractice) claims or lawsuits? YES NO
- If Yes, Number of Claims: _____
- If Yes, the Claims Information *MUST* be completed for each claim. Refer to Section X.
2. Have all claims been reported to your current or previous professional medical liability insurance carrier(s)? YES NO
3. Have you ever attempted or settled a claim on your own behalf that you did not report to a previous medical liability carrier? YES NO
4. Have you ever had any professional liability insurance declined, non-renewed or accepted malpractice insurance on special terms? YES NO
- If Yes, please explain: _____
5. Has any claim or suit been brought against you and/or any of your employees? YES NO
- If Yes, the Claims Information *MUST* be completed for each claim or suit. Refer to Section X.
- If Yes, has this information been reported to your current or prior insurance carrier? YES NO
6. Have you ever practiced without professional liability insurance? YES NO
- If Yes, please explain and specify dates: _____

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

MEDICAL PROCEDURES INFORMATION

Fairway Physicians Insurance Company uses the following definitions to clarify proper specialty classification. Please review the definitions, then proceed to indicate which procedures you perform if any.

No Surgery – Any practitioner who does not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin superficial fascia) and do not assist in surgery.

Minor Surgery – Any practitioner who assists in major surgery on their own patients, and performs catheterization, endoscopy (other than colonoscopy, proctocolonoscopy, or sigmoidoscopy), vasectomies, hemorrhoidectomies, diagnostic D & C's and vacuum curettage abortions during the first trimester of pregnancy.

Major Surgery – Any surgery other than “minor surgery” and assisting at major surgery on other than their own patients.

Do you perform any of the following procedures?

ACUPRESSURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	NON-FDA APPROVED DRUGS, PHARMACEUTICALS OR MEDICAL DEVICES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ACUPUNCTURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HYPOTHYROIDISM	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ALLERGY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IV THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ANTI-AGING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	NEURAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ARTHRITIS TREATMENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	NUTRITIONAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
AURICULOTHERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PAIN MANAGEMENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BARIASTRICS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PROLOTHETAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BIO-IDENTICAL HORMONAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RHEUMATOLOGY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BIO-OXIDATIVE THERAPIES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	THERMOGRAPHY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CANDIDIASIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ULTRAVIOLET LIGHT BLOOD IRRADIATION	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHELATION THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	WEIGHT MANAGEMENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHEMICAL SENSITIVITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO		<input type="checkbox"/> YES	<input type="checkbox"/> NO
COLON HYDROTHERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO		<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please describe any and all other procedures &/or treatments:

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION**XII. APPLICANT RETROACTIVE COVERAGE**

The following questions refer to your application for retroactive coverage (i.e. "Prior Acts" or "Nose Coverage") with Fairway Physicians Insurance Company ("FPIC").

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 FPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences subsequent to the retroactive date indicated in your certificate of insurance with FPIC.

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

Whether or not you believe you were at fault:

1. 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, etc?) YES NO
2. Are you, your employees or associates aware of any threats or complaints that could lead to legal action against you or your medical practice? YES NO

If Yes, please indicate the number of threats or complaints and describe below (use separate paper if necessary):

3. 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

OBLIGATION OF DISCLOSURE

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

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

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, FPIC 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 FPIC and the loss of all claims defense and claims payment services.

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

- NO, I decline retroactive coverage from FPIC.

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

I declare under penalty of perjury that the foregoing is true and correct. Executed this _____ of _____, 200_____ in _____, _____, by _____.
MONTH YR CITY STATE SIGNATURE
DAY

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION**XII. APPLICANT RETROACTIVE COVERAGE (CONTINUED)****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 FPIC 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 FPIC may be declined. I agree to notify FPIC 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 FPIC is governed by the terms of my FPIC policy. I agree that upon FPIC'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 FPIC to admit me as a member in FPIC, nor does it bind me to become a member of FPIC, if accepted. In addition, I understand and agree that I have no right to receive any information regarding the basis or reasons by FPIC 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 FPIC and payments for coverage have been received.

ARBITRATION: I agree that any dispute or controversy arising out of or in connection with this application shall be submitted to, determined and resolved by, binding arbitration before three (3) arbitrators. The arbitration shall be conducted pursuant to my underwriting policy.

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 FPIC 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 officers, 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 FPIC to assist me in securing professional liability coverage, I hereby authorize FPIC to release any and all necessary information to such individuals or agency/organizations.

NAME OF APPLICANT (PLEASE PRINT)

SIGNATURE OF APPLICANT

____ / ____ / ____
DATE

XIII. COVERAGE INFORMATION

1. Requested Effective Date: ____ / ____ / ____ Requested Retroactive Date: ____ / ____ / ____

IMPORTANT: The Declarations Page of your current policy must be attached if a retroactive date is requested. The company may not provide requested dates.

2. Policy Limits:

Coverage is solely as stated in your FPIC policy, and provided on a "Claims-Made" basis for those claims first reported (i.e. "Tail Coverage") against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I warrant to FPIC my understanding and acceptance of the notice stated above and that the information contained herein is true and shall be inclusive of the basis of the policy of insurance and deemed incorporated therein, should the insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of all claims information from any prior insurer to Fairway Physicians Insurance Company.

NAME OF APPLICANT (PLEASE PRINT)

SIGNATURE OF APPLICANT

____ / ____ / ____
DATE

Signing this application does not bind the applicant or the insurer or the underwriting manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.