Physicians' Reciprocal Insurers

Healthcare Facility
Physician Application

IMPORTANT: Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

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Roslyn, New York 11576
Telephone: (516) 365-6690 Fax: (516) 775-4224

HCF-PHYS-1 (11/12, Rev. 10/15, 3/16)

HEALTHCARE FACILITY PHYSICIAN APPLICATION

1. Name: _____ ☐ MD ☐ DO

Address:_____

City: _____State _____ ZIP_____

2. Name of Clinic/Center: _____

Address: _____

2a. Date of Hire: _____

3. Medical Specialty currently practiced: _____

3a. Subspecialty: _____

4. Medical School: _____ Country of Medical School: _____
Date of Graduation: _____

5. a) Place of Internship: _____ Date of Completion: _____

b) Place of Residency: _____ Date of Completion: _____

c) Place of Fellowship: _____ Date of Completion: _____

****** **Explain any gaps in time from date of medical school graduation to completion of residency in #28 COMMENTS****

6. Are you board certified in your specialtv? ___Yes ____ No
If no, are you board eligible? ____Yes ____No

6a. Are you board certified in your subspecialty? ___ Yes ___ Not
If no, are you board eligible? ___ Yes ___ No

7. NYS License Number _____ ____Permanent ____Temporary

7a. E.C.F.M.G. #, if applicable: _____

8. Social Security Number _____

9. Date of Birth: _____

10. How many hours per week do you work on behalf of the Clinic/Center? _____

11. What are your specific responsibilities and duties in regard to the work you perform for the Clinic/Center?
_____
_____

12. Do you have admitting privileges at any area hospitals? ___Yes ___No.
If Yes, please list in **#28 Comments**

13. Do you admit clinic patients for inpatient treatment? ___Yes ___No.
If Yes, provide the number of annual admissions _____

14. Do you wish coverage to extend to clinic patient admissions? ___Yes ___No

15. Do you perform any surgery on behalf of the Clinic/Center? ____Yes ____ No.
If Yes, explain in **#28 Comments**

16. Do you administer any anesthesia on behalf of the Clinic/Center? ____Yes ____ No.
If Yes, explain in **#28 Comments**

17. Do you now or intend to in the future, to supervise or perform any of the following procedures on behalf of the Clinic/Center?
If yes, indicate how many times per year:

	Yes	No		Yes	No
Acupuncture	___	___	Isotope Therapy	___	___
AIDS Treatment	___	___	Laparoscopy	___	___
Amniocentesis	___	___	Mammographs	___	___
Angiography	___	___	Myelography	___	___
Aspiration of Cyst of Breast	___	___	Needle Biopsy	___	___
Breast biopsy	___	___	Neonatal Care	___	___
Catheterization	___	___	Obstetrics	___	___
Cervical Biopsy	___	___	-prenatal or postpartum	___	___
Cervical Cautery	___	___	-deliveries or surgery	___	___
Chemotherapy	___	___	Peripheral nerve block	___	___
Closed reduction/fx.	___	___	Peritoneal Dialysis	___	___
Colonoscopy	___	___	Pneumoencephalography	___	___
Dermabrasion/Chemabrasion	___	___	Polypectomy by endoscope	___	___
Dilation & Curettage (D&C)	___	___	Proctoscopy	___	___
Duodenoscopy	___	___	Radiotherapy	___	___
Endometrial Biopsy	___	___	Sigmoidoscopy	___	___
Esophagoscopy	___	___	Splinting/casting of		
Foreign Body Removal from Eye	___	___	Non-displaced Fractures	___	___
Gastric Bubble	___	___	Sterilization Operations	___	___
Insertion of IUD	___	___	Repair of Laceration not		
Invasive Diagnostic Tests	___	___	involving Nerve or Tendon	___	___
Terminations of Pregnancy	___	___			

18. Have you **ever** had a malpractice claim or suit filed against you? ____Yes ____No.
If Yes, explain details in **#28 Comments**.

If yes, submit a separate form for each case in the last 10 years (See page 6)

19. Has any government agency **ever** investigated, revoked, suspended, restricted or taken any other action against either your narcotics license or your license to practice? ____Yes ____No.
If Yes, explain details in **#28 Comments**.

20. Have you **ever** been convicted of a crime? ____Yes ____No. If Yes, explain details in **#28 Comments**.

21. Have you **ever** had any privileges at any hospital or institution reduced, revoked, restricted or suspended? ___Yes ____No.
If Yes, explain details in **# 28 Comments**.

22. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? ____Yes ____No.
If Yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

23. Have you **ever** had professional liability insurance refused, declined, cancelled or accepted on special terms? ____Yes ____No.
If Yes, explain details in **#28 Comments**.

24. Name of your current malpractice insurer (if none, indicate "none"): _____
Limits of Liability: _____ Effective Dates: _____ Policy #: _____

25. Does this Malpractice Policy cover you for acts at the Clinic/Center? ____Yes ____No.

26. Coverage Type (Select coverage type:)

☐ Claims-Made - (A Claims-Made policy covers claims which arise and are made while the policy is in force.)

☐ Occurrence – (An Occurrence policy covers you against any claim arising during your policy period irrespective of when the claim is reported.)

27. Prior Acts

If your expiring policy is on a Claims-Made basis, an extended reporting period endorsement (Tail Coverage) is generally available as an option of your expiring Claims-Made policy.

a. Are you exercising this option with your previous or present carrier?
_____YES_____NO

b. If NO, do you want PRI to provide coverage for prior acts?
_____YES_____NO

c. If yes, what is the retroactive date _____

d. If prior acts coverage is not being requested, are you purchasing extended reporting (tail) coverage from your prior carrier?

_____ YES_____ NO

If Yes, please provide proof of tail coverage.

If No, please explain in **Comments (Item 28) on next page**.

Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

28. COMMENTS: _____

_____

_____

_____

_____

AGREEMENT: I understand that this insurance will only cover me for my professional services performed while acting within the scope of my duties at the insured healthcare facility, and while at the direction or request for the insured healthcare facility.

NOTICE

Applicants considering claims-made coverage must take note of the following:

A claims-made policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy.

The policy covers claims actually made against the insured and incidents reported while the policy remains in effect and all coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases additional extended reporting period coverage which will provide coverage for an unlimited time period without any gap in coverage.

The rates for extended reporting period coverage will be based on the rates in effect at the time of termination of coverage and such rate may be subject to substantial increase over the rates currently in effect. The average statewide percentage changes, and the effective dates, of each rate revision which PRI has implemented in this State during the five (5) year period immediately preceding the effective date of the policy will be provided upon the written request of the insured. Such past changes may or may not be indicative of future rate changes.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims-made or incidents reported after such period of sixty (60) days.

During the first few years of coverage on a claims-made basis, the annual rate is comparatively lower than occurrence rates, however, such annual rate increases significantly, independent of overall rate level increases, until the claims-made relationship reaches maturity.

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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____

Printed Name

_____ _____

Physician's Signature Date

Please make additional copies of this page, as necessary

CLAIM INFORMATION

1. Name of patient: _____2. Age: _____ 3. Sex: _____
4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____
5. Allegation: _____
6. Date of incident: _____ 7. Report date: _____8. Insurance carrier: _____
9. Other defendants: _____
10. Present Status: ☐Open Claim ☐Closed Claim Date closed: _____ Settlement or Judgement Amount: _____
11. Location of Incident: _____
12. Condition and diagnosis at time of incident: _____

    _____
13. Dates and description of treatment rendered: _____

    _____

    Condition of patient subsequent to treatment (including DATES OF FOLLOW-UP TREATMENT): _____

    _____

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Signed: _____ Date Signed: _____