80 Glastonbury Boulevard
Glastonbury, CT 06033
Phone: 800.228.0287
Fax: 800.403.3580
www.integrisgrp.com

Locum Tenens Professional Liability Application

If the application is approved, insurance will be afforded to the Locum Tenens physician who is temporarily substituting for an insured physician. Coverage for the Locum Tenens physician applies only to acts or omissions in providing professional services on behalf of and in the absence of the insured physician. The insured physician cannot provide professional services simultaneously with the Locum Tenens physician. The Integris policy includes 45 days of Locum Tenens coverage per insured physician, per policy year. If the insured physician's coverage or policy is cancelled and an additional Extended Reporting Period Endorsement is not obtained, coverage provided by the Locum Tenens Endorsement shall terminate as of the termination date of the insured physician's coverage.

NAMED INSURED INFORMATION

Named Insured: _____ Policy #: _____

Authorized Signature:_____ Date: _____

I. LOCUM TENENS INFORMATION

First: _____ Last Name: _____ Middle Initial: _____ Title: _____

DOB: _____ Gender: ☐M ☐F

Home Address:

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Email: _____

Office Address:

Employer/Group Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Office Manager: _____

Email: _____

II. EDUCATION – Copy of CV is required

Medical School: _____ Location: _____

Medical Specialty: _____

Sub-Specialty: _____

☐ Board Certified ☐Board Eligible ☐Other

Name of Specialty Board: _____

Board ID #: _____

Date of Certification: _____

Date of Recertification: _____

<u>License Information:</u>

Medical License #: _____

Exp. Date: _____

DEA License #: _____

Controlled Substance #: _____

NPI #: _____

Are you currently enrolled in a residency program? ☐Yes ☐No Fellowship Program? ☐Yes ☐No

Where: _____ Subject: _____

When will you complete the program? _____

How will you be supervised when working as a Locum Tenens? _____

Are you currently:

☐ Retired Date Retired: _____ ☐ Employed by a hospital or other institution which provides professional liability coverage for you ☐ Other: _____

III. COVERAGE INFORMATION

Desired Effective Date: _____

Do you currently have an individual professional liability policy through Integris Insurance Company or other insurance company? ☐Yes ☐No

If yes, explain and attach a copy of your current Declarations page (facesheet): _____

_____

Please attach a copy of your current Curriculum Vitae (CV).

Describe the duties you will perform as a locum tenens physician. Include any invasive procedures or procedures using contrast dye.

_____

_____

IV. CLAIMS INFORMATION

*Please note that the use of **claim** or **suit** in this application is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation*

1.	Are you or have you been involved in a malpractice claim or suit, either directly or indirectly? If yes, please indicate total number of claims and suits: _____ Open _____ Closed A Claim Addendum may be requested for open claims or suits.	☐Yes	☐No
2.	Have all claims and suits been reported to your current or prior professional liability carrier?	☐Yes	☐No ☐N/A
3.	Are you aware of any of the following circumstances regarding medical care you provided:		
A.	A letter or request for records from a patient or a patient's attorney or representative related to an adverse outcome from care you provided to a patient?	☐Yes	☐No
B.	A statement by or letter from a patient or patient's representative expressing dissatisfaction or questioning the quality or timeliness of any care you provided to a patient?	☐Yes	☐No
C.	A statement by or letter from a patient or patient's representative claiming a failure to provide care on your part or failure to diagnose?	☐Yes	☐No
D.	Intra- or post-procedural complications or other treatment complications resulting in death, paralysis, loss of body part or bodily function, disability, re-operation or extended hospitalization or other morbidity?	☐Yes	☐No
E.	Any death (expected or otherwise), neurological, sensory, or systematic deficits of a patient including but not limited to brain damage, permanent paralysis, loss of sight or hearing, loss of limb, or other morbidity from care you provided whether or not you believe that medical standards of care were met?	☐Yes	☐No
F.	Any permanent damage related to an injury during delivery of child or administration of anesthesia?	☐Yes	☐No
G.	Has a patient, patient's representative or representative filed any compliant or grievance to any healthcare institution, institution at which you practice and/or managed care organization of which you are a member, regarding care you provided to a patient?	☐Yes	☐No

H. Has a patient, patient's representative or any healthcare institution filed any governmental report (including Department of Public Health, and other state or federal agency) or grievance regarding care you provided to a patient?	☐Yes ☐No
I. Has your care ever been the subject of a peer review, sentinel event report or other investigation by any healthcare institution?	☐Yes ☐No
J. Are you aware of any expression of dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you whether from a patient or a patient's family or representative?	☐Yes ☐No
4. Have all circumstances that might reasonably lead to a medical incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐Yes ☐No ☐None to Report

V. COVERAGE HISTORY

Please provide Insurance history for a minimum of the last 10 years starting with most recent.

☐ I do not currently carry professional liability coverage.

Dates of Coverage	Insurer	Coverage Type	Tail Coverage Purchased	# of Pending Claims	# of Closed Claims	Total Claims	Premium
		☐Occurrence ☐Claims Made	☐Yes ☐No				$
		☐Occurrence ☐Claims Made	☐Yes ☐No				$
		☐Occurrence ☐Claims Made	☐Yes ☐No				$

VI. UNDERWRITING INFORMATION

1. Has any hospital or other health care facility ever denied, suspended, non-renewed, revoked, declined or in any way restricted your privileges or has probation ever been invoked?	☐Yes ☐No
2. Have you ever voluntarily agreed to surrender or modify your hospital or other health care facility privileges?	☐Yes ☐No
3. Has your medical license or narcotics license ever been denied, suspended, revoked, voluntarily surrendered, placed on probation or limited in any way?	☐Yes ☐No
4. Have you ever signed a consent order or consent agreement with, agreed to any sanction by, or been investigated by a state health department, state licensing board or other governmental body?	☐Yes ☐No
5. Have any complaints ever been registered against you with any employer, medical association/society, specialty board, hospital or other health care facility or state licensing authority or other governmental body?	☐Yes ☐No
6. Have you ever been denied certification by a specialty board?	☐Yes ☐No
7. Have you ever been arrested for any criminal offense, excluding misdemeanor in the past ten years?	☐Yes ☐No
8. Have you ever had any licensing board or professional ethics body require you to surrender your license or found you guilty of violations?	☐Yes ☐No
9. Are any of the actions in Items 1 - 8 above currently under investigation or consideration?	☐Yes ☐No
10. Do you now or have you ever had any chronic physical defect or any mental or emotional illness or disorder which impaired or could adversely affect your ability to practice to any degree?	☐Yes ☐No
11. Do you now or have you ever had a drug or alcohol addiction or dependency?	☐Yes ☐No
12. Do you use any drugs or devices which have been disapproved, or not yet approved, by the FDA for any use in human beings?	☐Yes ☐No

13. Has any insurance company ever cancelled, non-renewed, denied you professional liability insurance or offered you professional liability insurance only on special or restricted terms or at special rates?	☐Yes	☐No
14. Have you ever been accused or engaged in behavior defined as sexual misconduct?	☐Yes	☐No
15. Have you ever been denied a general anesthesia and/or Parenteral Conscious Sedation Permit?	☐Yes	☐No

Please read the following carefully, then sign and date the application in the space provided below.
I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. I AGREE to notify the Integris Insurance Company ("Company") promptly of any material changes in the information I have provided herein. I UNDERSTAND that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

DISCLOSURE AUTHORIZATION
I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record of knowledge concerning any of the statements and answers made by me herein to release such information the Integris Insurance Company ("Company") and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues. **I AUTHORIZE** the Company and such representatives to use a copy of this authorization in place of the original.

This authorization shall be valid for the period during which I am insured by or am seeking insurance from the Company. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

Signature of Applicant:

Print Name: _____ Title: _____ Date: _____

Signature: _____

Signature of Broker or Authorized Representative:

Print Name: _____ License #: _____ Date: _____

Signature: _____ Company: _____