



**MEDICAL ALLIANCE
INSURANCE COMPANY**

**PHYSICIAN
RENEWAL
APPLICATION**

Applications should be returned to:

**Association Management Resources
1151 East Warrenville Road
P.O. Box 3015
Naperville, IL 60566
Phone: 630-276-5658
Fax: 630-276-5403**

MAIC-A002-P
11/18/09

MEDICAL ALLIANCE INSURANCE COMPANY
PHYSICIAN PROFESSIONAL LIABILITY RENEWAL APPLICATION

1. **NAME OF INSURED(Last, First, Middle Initial)**

M.D. D.O.

2. **CONTACT INFORMATION**

If you answer yes to the following question, please provide an update in the space provided below.

- a) Has there been a change to your home address or phone number, your Illinois office address or phone number, or your billing address?

3. **CURRENT HOSPITAL PRIVILEGES**

<u>Hospital Name</u>	<u>City, State</u>	<u>Category of Privileges*</u>	<u>Est. % of Hosp. Practice</u>
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* Category of privileges includes full, restricted, courtesy or other.

4. **PRACTICE ACTIVITIES**

- a) Average weekly practice time in hours per week

Average weekly practice time includes clinical patient care, completion of medical records, in hospital on-call time, in hospital activities and consultations.

- b) Average number of patients per week

- c) How many days per week do you schedule patient appointments?

5. **PRACTICE UPDATES**

If you answer yes to any of these questions, please explain in the space following this section.

- a) Has there been a change to the county in which 51% or more of your office practice takes place?
- b) In the past twelve months, has there been a change in your employment relationship with a hospital?
- c) In the past twelve months, have you formed a medical corporation, changed the name of your existing medical corporation, or have any additional physicians joined your group practice?
- d) Has your practice (medical specialty, procedures, location) changed during the past year?
- e) Do you supervise any department within a hospital?
(NOTE: no coverage is provided for administrative duties)
- f) In the past twelve months, have there been any changes in your board certification status?

Please explain any “yes” answers

6. PROFESSIONAL ACTIVITIES

If you answer yes to any of the following questions, please explain on the comments page. (Page six)

- a) Has your membership in any professional society or association ever been refused, censured, suspended or revoked?
- b) Has your license to practice medicine or your narcotics license ever been denied, revoked, suspended or in any way limited?
- c) Has any hospital ever restricted, suspended or revoked your privileges or placed you on probation for any cause other than incomplete charts?
- d) Is there any action pending to restrict, suspend or revoke your privileges, license to practice medicine or narcotics license?
- e) Have your hospital privileges been expanded during the last twelve months to include procedures for which you completed additional training?
- f) Has any governmental authority or insurance company ever brought documented charges against you for alleged inappropriate fees?
- g) Have you ever been indicted or charged in a criminal suit?
- h) Have you ever been evaluated for, diagnosed with or treated for any mental, physical or chronic illness or any other impairment including alcoholism and substance abuse?
- j) Have any complaints ever been registered/filed against you with your medical association/society, hospital(s) or state licensing authority within the past ten years?
- k) Have you ever been denied a medical license or denied certification by a specialty board?
- l) Have you ever had your malpractice insurance canceled, non-renewed, restricted or special rated, or have you received a letter from your carrier of such intent?

7. CLAIMS

If you answer yes to the following questions, please complete the claims information on page five.

- a) Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?
- b) In the past year have any prior carriers settled a claim on your behalf or have any incidents or claims been dismissed or resolved in any way?

8. **PROCEDURES - Check if you perform any of the following:**

Minor Risk Procedures

Radiological Procedures

Angiography
Arteriography
Interventional radiology such as embolization, (including extra cranial), percutaneous transluminal angioplasty, percutaneous nephrostomy and drainage procedures
Therapeutic radiology, deep (includes radium implants)

Cardiovascular Procedures

Arterial, venous, cardiac or other diagnostic catheterization (includes insertion of cardiac pacemaker whether temporary or permanent). This does not apply to Swan-Ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel.
Percutaneous angioplasty with or without stent placement
Intracoronary streptokinase infusion
Pericardiocentesis
Myocardial Biopsy

Obstetrical/ Gynecological Procedures

Cervical conization and LEEP Procedures
Fallopian tube recanalization
Diagnostic/therapeutic D&C (does not apply to induced, nonspontaneous abortions)
Uncomplicated obstetrical care, either prenatal (which may include amniocentesis) and postpartum only and/or cephalic vaginal deliveries performed in a hospital which may also include episiotomy, application of low forceps only or obstetric vacuum cup.

Number of total deliveries you perform annually:

Number of normal vaginal deliveries you perform annually:

(Uncomplicated pregnancy, may include episiotomy and application of low forceps or vacuum cup)

Ophthalmic Surgery

Either extraocular only or extraocular and intraocular (includes surgery for glaucoma, cataract, retinal detachment and strabismus surgery--including YAG laser treatment for membrane opacity, laser trabeculoplasty and laser iridectomy and incision and curettage of chalazion of the eyelid)

Miscellaneous

Assisting in surgery
Interstitial hyperthermia
Ultrasound hyperthermia (superficial only)
MRI-Guided focused ultrasound for treatment of uterine fibroids
Vascular Access Procedures (primarily used for dialysis) including tunneled catheter insertion, vascular access angiography, vascular access thrombolysis and vascular access thrombectomy
Other Minor Risk Procedures, please explain:

What minor risk procedures do you perform in a clinic or other office based setting?

Major Risk Procedures -- if performing any of the procedures below please indicate the number of procedures performed annually.

Number Annually

Orthopedic

Closed reduction in dislocations other than fingers, toes and shoulders.
Open reduction of fractures or dislocations
Amputation other than digits
Any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to fracture
Orthopaedic surgery including obtaining an iliac crest bone graft and open procedures on the coccyx but excluding open procedures on the rest of the spine

Obstetrical

Cesarean Sections
Midforceps delivery
Version & extraction, 2nd Twin
Breech extraction
Multiple gestation
VBAC
Abortions, induced non-spontaneous
Chorionic Villi Sampling

Otorhinolaryngology

Elective Plastic Head and Neck Only
Elective Plastic Other than Head and Neck
Tonsillectomy/Adenoidectomy

Miscellaneous

Plastic Surgery-Cosmetic
Plastic Surgery-Reconstructive
Liposuction
Gastroplasty, gastric stapling, gastric partitioning or any like surgical procedure for the treatment of morbid obesity, obesity or weight reduction
Temporomandibular Joint Surgery including total replacement
Arthroscopy, alloplastic implants or meniscal repair via plaction
Spinal Surgery, Chemonucleolysis
Neurosurgery, Gamma Knife (Leskell Gamma Radiosurgical Unit)
Other Major Risk Procedures, please explain:

Claim information. If additional space is needed, please make a copy of this page

Patient Name		Date of Occurrence	
Insurance carrier covering claim		Date of Treatment	
Status (closed, open, incident)	Amt. paid or reserved	Date closed or settled	
Additional Defendants			
Allegation			

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Comments: Please provide details for any questions with a “yes” response (include question number)

I understand that MAIC's consideration of this application does not bind MAIC to provide insurance and that all information requested and the responses provided in this application are material to MAIC's decision to provide or deny insurance coverage. If MAIC agrees to provide insurance, I understand that the policy will be void if I conceal any important information or mislead or attempt to defraud or lie about any matter contained in this application.

By signing this application, I verify and affirm that the information contained in this application and the attachments which are part of the application are true and correct and not misleading.

Signature of applicant

Date

Note: You must sign the attached Authorization and Consent Form as part of this application.

AUTHORIZATION AND CONSENT

I hereby authorize Medical Alliance Insurance Company and its agents, Illinois Risk Management Services and Association Management Resources (collectively “The Companies”) to investigate and obtain any information bearing upon my moral character, professional reputation, competence or fitness to engage in the activities authorized by my license to practice medicine and I hereby authorize and consent to any hospital, physician, clinic or other healthcare provider releasing to “The Companies” any such information which it is permitted by law to disclose.

I also authorize and consent to any insurance company, self-insured trust, other risk-sharing program and attorneys representing me to provide information to “The Companies” concerning any event, claim, lawsuit or cause of action involving the undersigned.

A photocopy of this authorization shall be accepted as if it were the original.

Dated this _____ day of _____ 20 _____.

Signature