

**Nebraska Residual Malpractice Insurance Authority
Professional Liability Application
Occurrence Form**

PART A – APPLICANT INFORMATION

1. Last Name		First Name		M.I.	
2. DOB ____/____/____		3. SSN ____ - ____ - ____		4. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
5. Home Address					
City		State		Zip	
6. Primary Practice Address					
City		State		Zip	
Office Phone #			Office Fax #		
Additional Contact #			e-mail address		
7. Current Form of Insurance <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims- Made		Retroactive Date (if applicable)		Current Carrier	
Limits of Coverage		Dates of Coverage ____/____/____ to ____/____/____		Currently Participating in the Act <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART B – COVERAGE REQUESTED

8. Requested Effective Date ____/____/____	
9. Are you requesting coverage for your Professional Corporation or Employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If “yes” please indicate which one and/or both. <input type="checkbox"/> Professional Corp. <input type="checkbox"/> Employee(s)	
10. Type of practice <input type="checkbox"/> Physician <input type="checkbox"/> Intern/Resident <input type="checkbox"/> Certified Registered Nurse Anesthetists	Member of: <input type="checkbox"/> Professional Corp. <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Corp. <input type="checkbox"/> Other _____

11. If you are practicing as a solo entity, as a member of a multi-shareholder entity such as a partnership, limited liability corporation, professional corporation, limited liability partnership or professional association or are in another type of group practice such as an implied partnership or corporation, please provide the exact legal names of all medical entities to be insured. **Please remember to attach to the application a copy of each entity's current declarations page.** Please use the Notes Section if additional space is needed.

Entity Names:

Involvement/Ownership:

Limited Partner General Partner Solo Ownership DBA

Limited Partner General Partner Solo Ownership DBA

Limited Partner General Partner Solo Ownership DBA

12. Please give the full names of all other physicians affiliated with any organization(s) or medical entities named in question 11, their specialties and the name of their current medical professional liability insurer. **All affiliated physicians must complete a separate application if organization or entity coverage is requested.** Please use the Notes Section if additional space is needed.

Name:	Specialty:	Current Insurance:

13. Employer Name _____

14. Name of any other entity with which you are associated or affiliated _____

15. Please list **all** employees' names, professional occupations, their license numbers and the name of their current medical professional liability insurer, of those that are to be included as **additional insureds** (i.e. PA, RN, LPN, etc.). Please use the Notes Section if additional space is needed.

Name:	Occupation:	License Number:	Current Insurance:

PART C – LICENSE INFORMATION

16. List **all** states in which you have ever been or are currently licensed to practice medicine, the license number for that state, the date the license was issued and the percentage of your current practice in that state. (Please use the Notes Section if additional space is needed.)

State	License Number	Date Issued	Number of hours per week	Status of License
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive

PART D – PROFESSIONAL LIABILITY INSURANCE HISTORY

17. Please list your previous insurance coverage

Name of Company (Current)	Policy Limits \$_____/ \$_____	Period of Coverage: ___/___/___ to ___/___/___ Retroactive Date: ___/___/___	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company (Previous)	Policy Limits \$_____/ \$_____	Period of Coverage: ___/___/___ to ___/___/___ Retroactive Date: ___/___/___	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company (Previous)	Policy Limits \$_____/ \$_____	Period of Coverage: ___/___/___ to ___/___/___ Retroactive Date: ___/___/___	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence

If your current insurance is claims-made, will “tail coverage” be purchased**? Yes No

**This coverage is provided on an occurrence form only, prior acts coverage is not available. Therefore, in order to have coverage for you previous acts you must purchase tail coverage from your current insurer as well as the Nebraska Excess Liability Fund.

PART E – EDUCATION

18. Please list your education history.			
Name of Medical/Osteopathic School	Degree	Location	(Mo./Yr.) (Mo./Yr.) From To

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG?)..... Yes No

19. Please list any and all Internship(s), Residency(ies) and Fellowship.					
	Program Name	Department	Location	(Mo./Yr) (Mo./Yr.) From To	Program Completed
Internship Served					<input type="checkbox"/> Yes <input type="checkbox"/> No*
Residency(ies)					<input type="checkbox"/> Yes <input type="checkbox"/> No*
					<input type="checkbox"/> Yes <input type="checkbox"/> No*
					<input type="checkbox"/> Yes <input type="checkbox"/> No*
Fellowship(s)					<input type="checkbox"/> Yes <input type="checkbox"/> No*
					<input type="checkbox"/> Yes <input type="checkbox"/> No*

*** If “No” is indicated, explain fully in the Notes Section.**
Please explain any gaps in your medical education in the Notes Section. “Gaps” are defined as periods of time of 90 days or more in which you were not actively enrolled in an internship, residency, fellowship or preceptorship program.

PART F – PRACTICE HISTORY

20. List your professional practice history for the past 5 years.		
Location	Type of Practice/Position	(Mo./Yr.) (Mo./Yr.) From To

Please explain any gaps in your practice history in the Notes Section. “Gaps” are defined as periods of time of 90 days or more in which you were not actively practicing medicine.

21. What is your Specialty? _____

22. What is your Subspecialty? _____

23. Has your Specialty or Subspecialty changed in the last 5 years? Yes* No
 *If yes, please describe the nature of changes in specialty, classification or practice activities in the Notes Section.

24. Percentage of your practice devoted to your Specialty _____

25. Percentage of your practice devoted to your Subspecialty _____

26. What professional organizations are you a member of?
 AMA State Medical Other _____
 AOA County Medical

27. Are you certified by an approved specialty board?
 Yes No Name _____
 Date of initial certification _____ Date(s) of recertification _____

28. Have you ever been denied board certification or recertification? Yes* No
 If "yes" please explain in the Notes Section.

PART G – PRACTICE CHARACTERISTICS

29. List all hospitals as which you have or will have staff privileges in force for which you are requesting this coverage and indicate the type of privileges you hold at each:

<u>Name of Hospital</u>	<u>Type of Privilege</u>
_____	Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other <input type="checkbox"/>
_____	Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other <input type="checkbox"/>
_____	Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other <input type="checkbox"/>
_____	Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other <input type="checkbox"/>
_____	Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Other <input type="checkbox"/>

Please explain any "pending" or "other" answer here. If you explain a "pending" answer, please provide the date you initially applied for these privileges. _____

If additional space is needed, please use the Notes Section.

30. If you made no entry in #29 above, please provide details regarding your patients who require hospital care including the names and practice locations of all physicians who will follow them while hospitalized.

31. After the Requested Effective Date, do you plan to practice/consult outside Nebraska in the next 12 months?

Yes No

If "yes" you will need to maintain other professional liability insurance this exposure, as the Nebraska Residual Fund will only provide coverage for your Nebraska exposure.

32. Do you participate in telemedicine?

Yes* No

(For purpose of this question, telemedicine is defined as "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual patient as a result of transmission of individual patient data by electronic means." Telemedicine does not include an informal consultation provided without compensation or expectation of neither compensation, nor does it include those services described above which are rendered in a bona fide emergency.)

If "yes" please explain in the Notes Section.

33. If you are a radiologist or pathologist, do you or will you read, interpret or diagnose films, slides or specimens taken of patients who reside outside the state of Nebraska?

Yes No

If "yes", please indicate the state(s) or foreign country(is) in which the patients being treated reside:

And the number of hours per week you will devote in each state or foreign country: _____

34. Do you assist at surgery?

Yes No

35. In your practice, do you perform procedures or use equipment not used by a majority of physicians in your specialty who practice in Nebraska?

Yes No

If "yes" please explain _____

36. Do you perform any procedures that are non-FDA approved? Yes No

If "yes", please list all procedures. _____

37. Do you perform any of the following procedures?

- | | | |
|--|------------------------------|-----------------------------|
| Autologous fat injections into breasts or penises | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chelation therapy (other than for treatment of heavy metal poisoning) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cymopapain disc injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Elective home delivery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Intravascular absolute alcohol embolization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prolotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rapid opiate detoxification | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sclerotherapy (the injection of sclerosing agents) into the vertebral column | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sperm banks for other than interim storage for insemination of your own patients | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Transsexual surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use of chorionic gonadotropin in the treatment of obesity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use of Laetrile (Amygdalin or vitamin B-17) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

38. Do you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure? Yes No

39. Do you supervise CRNAs who provide general anesthesia? Yes No

40. Do you perform obstetrical procedures? Yes No

If "yes", please indicate the average number of deliveries performed per year _____ and the average number of C-sections performed per year _____.

41. If you are a Family Practitioner performing obstetrics, do you have privileges to perform C-sections at each hospital you staff? Yes No

If "no" please provide full details of your back-up arrangements including coverage for VBAC patients.

42. Other than to maintain hospital privileges, do you practice in an Emergency Department? Yes No

If "yes", please indicate number of hours per week. _____

43. Do you or will you perform conscious sedation? Yes No

If "yes", do you or will you?

- | | | |
|---|------------------------------|-----------------------------|
| a. utilize reversal agents at bedside? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. maintain the ability to breathe for the patient? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. ensure that continuous and constant patient monitoring is done by a qualified person from the initiation of sedation until the patient is cleared for discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For purpose of this question, "monitoring" is defined as observing and recording a patient's pulse oximetry, vital signs and depth of sedation.

44. Do you perform “invasive” procedures? Yes No

“Invasive” refers to procedures by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation. If “yes” list all such procedures:

Procedure	Resident-Trained?	Hospital-Privileges?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

45. Do you perform:

- | | |
|---|--|
| Prenatal care beyond the first trimester? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Second-trimester abortions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C-Sections? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angiography? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast biopsy by surgical incision? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac catheterization? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liposuction surgery using the tumescent technique? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liposuction surgery using any technique other than tumescent? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reduction of open fractures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reduction of undisplaced closed fractures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reduction of displaced closed fractures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

46. In your practice, do you utilize FDA experimental drugs other than through Institutional Review Board (IRB) approved research programs? Yes No

If “yes”, will the study indemnify your? Yes No

47. Do you use a physician/patient arbitration agreement in your practice? Yes No

For this purposes of this question, “physician/patient arbitration agreement” refers to a document you ask patients to sign prior to providing healthcare services which stipulates that any dispute between you and the patient will be submitted to arbitration as opposed to resolution in the state or federal courts.

PART I – OTHER INFORMATION

All “yes” answers require explanation in the Notes Section

48. Has any professional liability insurer ever canceled, declined to issue, refused to renew, or issued coverage with any restrictions or exclusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
49. Has any disciplinary action ever been taken against any healing arts license that you hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. (Disciplinary actions, include, but are not limited to, suspension, revocation, probation, practice limitation, reprimand, letter of admonition, censure and any allegations which are currently pending)	<input type="checkbox"/> Yes <input type="checkbox"/> No
50. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily, surrendered, or otherwise investigated or limited, in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No
51. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
52. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? Note: You must answer “yes” even if charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do <u>not</u> include alcohol or drugs.	<input type="checkbox"/> Yes <input type="checkbox"/> No
53. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
54. Have you incurred or suffered any chronic illness or physical injury in the past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
55. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
56. Have you ever failed any licensing or Board certification examinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
57. Have you ever had a patient or patient representative complain to or file a grievance of any type with a hospital committee, State Licensing Board, Board of Medical Examiners, health plan, managed care organization, or other medical review committee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
58. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction or mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
59. Have you every been accused of sexual misconduct or harassment by one of your employees, an associate’s employee or an employee of a hospital or surgery center, or have you been accused by a patient of or been investigated by any state regulatory authority in connection with boundary violations of a sexual nature?	<input type="checkbox"/> Yes <input type="checkbox"/> No
60. Have you ever been reported to the National Practitioners Data Bank?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART J – CLAIMS INFORMATION

Important information regarding questions 63 and 64 (including sub-questions):

1. The word “claim” as used in Questions 63 and 64 below refers to:
 - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer “yes” to questions 63 and/or 64 (including sub-questions) please complete the attached Supplementary Claims Information Form.

61. Have you <u>ever</u> been involved in a malpractice claim or suit, either directly or indirectly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
62. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. A request for records from a patient and/or attorney related to an adverse outcome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. A letter from an attorney regarding your medical treatment of a patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Intra-operative or post-operative complications or other complication resulting in death, paralysis, or other significant disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Any other circumstances that might reasonably lead to a claim or suit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Have all circumstances that might reasonably lead to a 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?	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
i. If “yes” how many? _____ Please attach documentation of all such reports.	
ii. If “no”, please explain in Notes Section.	

For purpose of this question “N/A” means that you are not aware of any circumstances that might reasonably lead to a claim or suit.

Signing this application does not bind the Authority to provide the insurance. All information requested in this application is considered material and important. If the Authority agrees to be bound under the terms of this application, your policy is void if you hide or withheld any important information, mislead, or attempt to defraud the Authority in any matter contained in this application. Also, your signature grants authorization to contact your previous carrier to secure further underwriting information, if deemed necessary. If this application is approved by the Nebraska Residual Authority, coverage will not begin until premium payment is received.

Signature of Applicant: _____ **Date:** _____

Name of Applicant (Print) _____

PART K – SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. All questions must be answered or marked Not Applicable (N/A)

1. Patients name _____

2. Date reported to insurance company _____

3. Name of insurance company _____

4. Date of incident and your treatment: _____

5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

<p>8. Status of claim (check applicable answer):</p> <ul style="list-style-type: none"><input type="checkbox"/> Suit threatened, no action taken<input type="checkbox"/> Suit filed but dropped by claimant<input type="checkbox"/> Awaiting mediation<input type="checkbox"/> Awaiting court action<input type="checkbox"/> Summary judgment in your favor<input type="checkbox"/> Court outcome in your favor<input type="checkbox"/> Court outcome in favor of plaintiff<input type="checkbox"/> Suite settled out of court	<p>9. Payment Information:</p> <ul style="list-style-type: none">a. Date claim was paid: _____b. Reserve Amount: \$ _____c. Amount paid: \$ _____d. Amount of loss payment \$ _____e. Did you want to settle this claim <input type="checkbox"/> Yes <input type="checkbox"/> No
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10. To you knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes No

Signature: _____ **Date:** _____

Name (Printed): _____

