Fairway Physicians Insurance Company
A Risk Retention Group

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION

FOR PHYSICIANS & SURGEONS

Application Instructions & Checklist

Prior to completing the application, please read the following instructions. Please verify that all required attachments are included in order to assist us in processing your application promptly.

Instructions

1 Please type or print.

2 Answer all questions. If a question does not apply, mark "N/A" (Not Applicable). Do not leave any question unanswered. If an answer requires more detail, please use the **Remarks Section** or attach additional documentation.

3 Application must be signed and dated by the owner, partner or officer.

4 Please carefully read the statements at the end of the application.

Required Attachments

- ☐ Please attach a copy of your **CURRENT curriculum vitae (CV) -** CV must include medical school training and practice history information.
- ☐ Please attach a copy of your **CURRENT Declarations Page** from your current policy showing your policy period, limits of liability, and retroactive date.
- ☐ Please attach a copy of your **CURRENT loss runs** from all insurance carriers that insured you for the past seven years (if applicable).
- ☐ Please attach a copy of your **CURRENT letterhead**.

Please submit the completed application and the required attachments by email, fax, or mail to:

Fairway Physicians Insurance Company, RRG ("FAIRWAY")
30401 Agoura Road, Suite 101
Agoura Hills, CA 91301
Fax (818) 979-8003
Email submissions@fairwayphysicians.com

If you need assistance with the application,
please call (800) 859-7013 to speak with a FAIRWAY Representative.

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

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION

FOR PHYSICIANS & SURGEONS

Requested Effective Date: MM/DD/YYYY **Requested Retroactive Date:** MM/DD/YYYY

Contact Information

1 Name: First M.I. Last Title:

2 Date of Birth: MM/DD/YYYY Social Security Number: Gender: ☐ Male ☐ Female

3 Driver's License #: Employer IRS #

4 Primary Office Address: Street City State Zip Code

Office Phone: Office Fax:

Email: Website:

Contact Person:

5 Home Address: Street City State Zip Code

Home Phone: Mobile Phone:

6 Please list all other office locations for which you are requesting coverage.

7 Please list all hospitals where you have privileges.

8 Please indicate billing address: ☐ Primary Office ☐ Home ☐ Other

9 How did you hear about FAIRWAY?

Practice Information

10 Primary Specialty: % of Practice:

Secondary Specialty: % of Practice:

11 Are you ABMS Certified? ☐ Yes ☐ No If Yes, date of certification or recertification: MM/DD/YYYY

12 Are you Board Eligible? ☐ Yes ☐ No Date of Board Exams taken by you: MM/DD/YYYY

13 Please list all medical licenses (State, License #):

14 Please indicate your average total number of hours worked per week:

15 Please estimate the number of patient visits per week:

16 Practice type: ☐ Partnership ☐ Corporation ☐ Individual ☐ Solo/Proprietor Using a DBA

☐ Employee ☐ Office Sharing Arrangement ☐ Member of a Multiperson Corporation/Association

Practice Information (Continued)

17 Name of Entity: _____ DBA: _____

18 Please list the names of all physicians and surgeons you employ, contract with, supervise and/or practice with in an office setting.

_____

* If you are requesting coverage with FAIRWAY, each physician must complete their own Physicians & Surgeons Application and coverage is subject to underwriting approval and payment of premium.

19 With whom do you share call?

_____

20 Please list the names of all non-physicians you employ, contract with, supervise and/or practice with in an office setting who provide direct patient care.

_____

* If you are requesting coverage with FAIRWAY, each person must complete their own Allied Healthcare Application and coverage is subject to underwriting approval and payment of premium.

21 Please indicate the number of each of the following who provide services for your practice (excluding yourself).

Nurse Midwives: _____ Nurse Practitioners: _____ Physician Surgical Assistants: _____

Nurse Midwife Assistants: _____ Physician Assistants: _____ Other: _____ : _____

22 Does your practice include a surgicenter or laboratory? ☐ Yes ☐ No

If **Yes**, please answer the following:

a) Where is this facility located? ☐ On-site ☐ Off-site

b) Does this facility provide services solely for your patients? ☐ Yes ☐ No

c) Will non-FAIRWAY insured physicians use this facility? ☐ Yes ☐ No

23 Do you have a full ACLS Resuscitation (crash) cart in your office? ☐ Yes ☐ No

If **Yes**, are you ACLS Certified? ☐ Yes ☐ No Expiration Date (If Applicable) MM/DD/YYYY _____

24 If you answer **Yes** to any of the following questions, please indicate your % of practice, provide details in the **Remarks Section** and attach any applicable, supporting documentation.

a) Do you require coverage as a proprietor, partner, officer, director, administrator, or medical director in any medical enterprise? ☐ Yes ☐ No

b) Do you provide medical services as a designated sports team physician? ☐ Yes ☐ No _____ %

c) Do you provide medical services for persons in nursing homes / assisted living facilities? ☐ Yes ☐ No _____ %

d) Do you provide medical services for persons in correctional facilities? ☐ Yes ☐ No _____ %

e) Do you engage in telemedicine activity? ☐ Yes ☐ No

f) Do you provide diagnosis via the internet or phone? ☐ Yes ☐ No

Insurance Information

25 Current Carrier: _____ # of years with carrier: ____ Current Premium: _____

If you have been with your current carrier for less than 5 years, please provide the names of your previous carrier(s) and policy term(s) in the Remarks Section.

26 Requested Limits of Liability: _____ per claim _____ aggregate

27 If you answer **Yes** to any of the following questions, please provide details in the **Remarks Section** and attach any applicable, supporting documentation.

a) Have you ever stopped practicing medicine for an extended period of time? (e.g. leave of absence, sabbatical, pregnancy, etc.) ☐ Yes ☐ No

b) Have you ever practiced without professional liability insurance? (e.g. gap in coverage) ☐ Yes ☐ No

c) Have you ever had your hospital privileges suspended, denied, restricted, placed in probationary status or revoked? ☐ Yes ☐ No

d) 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

e) Have you ever been charged with or convicted of a crime other than minor traffic violations? ☐ Yes ☐ No

f) 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

g) Has any professional liability carrier ever denied, terminated, restricted, or modified your professional liability coverage? (e.g. surcharges, co-payments, or deductibles) NOTE: MISSOURI APPLICANTS DO NOT RESPOND ☐ Yes ☐ No

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).

28 Whether or not you believe you are at fault, if you answer **Yes** to any of the questions below, you must complete the **Claims Information** section.

a) Have you ever had a "claim" or attempted to settle a "claim" on your own behalf? ☐ Yes ☐ No

DEFINITION: For purposes of this Application a "claim" is an expression of dissatisfaction or demand **for** something as a right or as due **from a patient or on a patient's behalf**. A "claim" includes, but is not limited to, a letter expressing dissatisfaction, **a notice of intention to sue, a lawsuit, a counterclaim or a demand for arbitration**.

b) 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) ☐ Yes ☐ No

c) Are you, your employees, or associates aware of any threats or complaints against you or your medical practice? ☐ Yes ☐ No

d) 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

Procedures & Treatments Information

29 Please indicate if you or your staff perform the following procedures:

	Physician	Non-Physician Licensed Staff	Non-Licensed Staff
Botox Injection	☐	☐	☐
Chemical Peel	☐	☐	☐
Cosmetic Tattooing	☐	☐	☐
Laser Hair Removal	☐	☐	☐
Laser Wrinkle Removal	☐	☐	☐
Microdermabrasion	☐	☐	☐
Permanent Make-Up	☐	☐	☐
Sclerotherapy	☐	☐	☐
Other Cosmetic Procedures	☐	☐	☐

30 Please list any procedures or treatments you perform for which you did not receive training in your residency or that are outside the customary scope of practice for your specialty.

31 Please list any procedures or treatments that you have discontinued in the past 10 years.

32 Do you use any non-FDA Approved Drugs, Pharmaceuticals or Medical Devices? ☐ Yes ☐ No

33 Do you perform any emergency room duties or work at an urgent care facility? ☐ Yes ☐ No

34 Please select all treatments and procedures that you perform and indicate the % of your practice where requested. Use the **Remarks Section** and attach any applicable, supporting documentation for all other procedures or treatments you perform not listed below.

- ☐ Abdominoplasty
- ☐ Abortions - Elective ___ %
- ☐ Abortions - Therapeutic ___ %
- ☐ Acupuncture
- ☐ Allergy Treatments
- ☐ Anesthesia - General/Spinal/Caudal
- ☐ Angiography
- ☐ Angioplasty
- ☐ Anti-Aging Treatments
- ☐ Arteriography
- ☐ Arthritis Treatments
- ☐ Arthroscopy
- ☐ Assisting in Surgery - Own Patients
- ☐ Assisting in Surgery - Other Patients
- ☐ Bariatric Surgery
- ☐ Bio-Identical Hormone Therapy
- ☐ Biopsy - Endoscopic
- ☐ Blepharoplasty ___ %
- ☐ Brachioplasty
- ☐ Breast Implants - Cosmetic ___ %
- ☐ Breast Implants - Reconstruction ___ %
- ☐ Breast Reduction ___ %
- ☐ Bronchoscopy
- ☐ Bronco-esophagology
- ☐ Candidiasis
- ☐ Cataract Surgery
- ☐ Catheterization
- ☐ Chelation Therapy
- ☐ Chemical Sensitivity
- ☐ Cleft Lip/Palate Surgery
- ☐ Colon Hydrotherapy
- ☐ Colonoscopy
- ☐ Convulsive/Shock Therapy
- ☐ Cryosurgery
- ☐ D&C
- ☐ Electromagnetic Therapy
- ☐ Embolization
- ☐ Endoscopy
- ☐ Face Lifts ___ %
- ☐ Gynecology - Major Surgery
- ☐ Hair Transplants
- ☐ Hypothyroidism
- ☐ Intrathecal Pumps
- ☐ I.V. Therapy
- ☐ Kyphoplasty
- ☐ Laparoscopy
- ☐ Laminectomy
- ☐ Laser Surgery
- ☐ Laser Therapy
- ☐ Lipoinjection ___ %
- ☐ Liposuction ___ %
- ☐ Lithotripsy
- ☐ Lymphangiography
- ☐ Mammograms
- ☐ Myelography
- ☐ Nerve Blocks
- ☐ Neural Therapy
- ☐ Other Implants
- ☐ Oxidation Therapy
- ☐ Ozone Therapy
- ☐ Pain Management
- ☐ Peritoneoscopy
- ☐ Phlebography
- ☐ Pneumoencephalography
- ☐ Polypectomy
- ☐ Prenatal Care
  - ☐ 1st & 2nd Trimester
  - ☐ to term, no delivery
  - ☐ to term, and delivery
  - ☐ Normal Deliveries - per year ___
  - ☐ Cesarean Deliveries - per year ___
- ☐ Penial Implants
- ☐ Prolotherapy
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye
- ☐ Rheumatology
- ☐ Rhinoplasty ___ %
- ☐ Sigmoidoscopy
- ☐ Silicone Injections ___ %
- ☐ Skin Flaps/Grafts ___ %
- ☐ Spinal Cord Stimulators
- ☐ Thermography
- ☐ Tubal Ligations
- ☐ U.V. Light Blood Irradiation
- ☐ Vasectomies
- ☐ Vertebroplasty
- ☐ Weight Control Medication

Claims Information

Please copy this page for all additional claims you are reporting to FAIRWAY.

NOTE: This **Claims Information Form** pertains to lawsuits, claims or demands for arbitration or incidents which could lead to claims. A claims form must be completed for each lawsuit, claim, demand for arbitration or incident. Sufficient information must be provided to evaluate medical aspects of the case specifically relating to the physician's involvement.

1 Patient's Name: _____ Age: ____ Gender: ☐ Male ☐ Female

2 Your relationship to the patient (i.e. Attending Physician, Primary Physician)

_____

3 Date of Incident: MM/DD/YYYY Date Reported: MM/DD/YYYY Location: _____

4 Insurance Carrier: _____ Other Defendants: _____

5 Present Status: ☐ Open ☐ Closed MM/DD/YYYY

☐ Incident Only ☐ 90-Day Notice ☐ Suit Filed ☐ Suit Served ☐ Arbitration

Method of Closing: ☐ Dismissed ☐ Defense Verdict

Settled: Amount Paid On Your Behalf: _____ Total Settlement: _____

Judgment: Amount Paid On Your Behalf: _____ Total Settlement: _____

6 The following questions should be answered in explicit, clinical detail to allow proper evaluation by the Fairway Underwriting Department. Attach additional sheets as required.

a) Patient's allegations or circumstances brought to your attention:

_____

_____

b) Dates and description of treatment rendered:

_____

_____

c) Condition of patient subsequent to treatment (and dates of follow-up treatment):

_____

_____

7 **I understand information submitted herein becomes part of the FAIRWAY's Named Insured's records.**

Date: MM/DD/YYYY Physician Name (Printed): _____

Physician Signature: _____

Remarks Section

Please use this page to provide any additional information and be sure to reference the question number that the information applies to.

Question #

Agreements, Disclosures & Notices

APPLICANT RETROACTIVE COVERAGE

The following statements refer to your application for retroactive coverage with Fairway Physicians Insurance Company, A Risk Retention Group ("FAIRWAY").

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

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

OBLIGATION OF DISCLOSURE

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

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

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, FAIRWAY 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 FAIRWAY and the loss of all claims defense and claims payments services.

Requested Retroactive Date: MM/DD/YYYY

☐ **NO**, I decline retroactive coverage from FAIRWAY.

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

I declare under penalty of perjury that the foregoing is true and correct. Executed this *Day* of *Month*, *Year* in *City*, *State*, by *Signature*

Agreements, Disclosures & Notices (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 FAIRWAY 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 FAIRWAY may be declined. I agree to notify FAIRWAY 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 FAIRWAY is governed by the terms of my FAIRWAY policy. I agree that upon FAIRWAY'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 FAIRWAY to admit me as a member in FAIRWAY, nor does it bind me to become a member of FAIRWAY, if accepted. In addition, I understand and agree that I have no right to receive any information regarding the basis or reasons by FAIRWAY 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 FAIRWAY and payments for coverage have been received.

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

Name of Applicant (Please Print): _____

Signature of Applicant: _____ Date: MM/DD/YYYY