ISMIE Mutual Insurance Company
The Physician-First Service Insurer

Processing Number _____

ATTN: UNDERWRITING DIVISION

Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
Telephone 312-782-2749
Toll Free 800-782-4767
Fax 312-782-2023
www.ismie.com

Application for Individual Physician Professional Liability Insurance

Please choose your desired coverage option either claims-made or occurrence. It is important for you to discuss which coverage type to apply for with your employer, if any, prior to submitting an application to ISMIE.

Claims-Made Coverage ☐

"A claims-made policy is limited to claims which are first made while the policy is in force and arise out of professional services provided on or after the retroactive date stated in the Declarations page and as defined in the policy."

Occurrence Coverage ☐ (Not Available in Florida)

"An occurrence policy is limited to claims that arise out of professional services rendered during the policy period stated in the Declarations Page and as defined in the policy."

Instructions: It is essential that all statements be completed and all questions answered. If the answer to any question is "**no**", be certain to check "**no**" on the Application. **Please do not leave any questions unanswered. If additional space is required to answer any questions, use the "Remarks Addendum."** Please print your answers, but do not write in shaded areas.

1. Physician Name:

First Middle Last Title

☐ Male ☐ Female

2A. Name of ISMIE Mutual – insured Physician, Corporation, or Clinic you are joining, if applicable.
(Disregard if you are applying as an individual.)

2B. Indicate all states of practice where ISMIE Mutual coverage is desired:

3. Desired effective date of coverage (12:01 a.m. Standard Time):

Month / Day / Year

4. Desired retroactive date for Claims-Made Coverage. (12:01 a.m. Standard Time): Retroactive date is required to secure prior acts coverage (nose coverage). Only applicable for Claims-Made Coverage, leave blank if applying for Occurrence Coverage.

Month / Day / Year

Physician General Information

5. Date of Birth: _____ **6. Social Security Number:**_____

7. Home Address:_____

_____

City: **State:** **Zip Code:**

Telephone: ( ) - **Fax: ( ) -** **E-Mail Address:**

8 a. ***(include copy of license)***
Medical License Number:_____
State: _____
8 b. ***(include copy of license)***
Medical License Number:_____
State: _____
8c. ***(include copy of license)***
Medical License Number:_____
State: _____

9 a. ***(include copy of license)***
Controlled Substance Number:_____
State:_____
9 b. ***(include copy of license)***
Controlled Substance Number:_____
State: _____
9 c. ***(include copy of license)***
Controlled Substance Number:_____
State:_____

10. DEA Number:_____

10a. NPI Number:_____

11 a. Mailing Address:
Note: This address is where all of your insurance documents and correspondence will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

11 b. Billing Address: **Same as 11a.** ☐
Note: This address is where all of your insurance premium invoices and notices will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

12. Previous Insurance Carriers - Last ten years: *

Carrier Name	Policy Period	Limits	Claims-Made	Occurrence
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

***It is necessary that you obtain a current Loss History from each carrier listed above for a ten year period in order to be considered for the maximum loss free discount credits. While we will accept five years of loss history to underwrite your application, we will not be able to consider full loss free discount credits without receiving your complete ten year loss experience.**

13. Medical School:

Name _____ Year Graduated: _____

City _____ State _____ Country _____ Degree: _____

14A. Residency Information:
Name of Hospital/Facility:

_____

City _____ State _____ Country _____

Specialty:_____

From: _____ To: _____
mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

14B.
Name of Hospital/Facility:

_____

City _____ State _____ Country _____

Specialty:_____

From: _____ To: _____
mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

15A. Additional Training
Name of Hospital/Facility:

_____

City _____ State _____ Country _____

Specialty:_____

From: _____ To: _____
mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

15B.
Name of Hospital/Facility:

_____

City _____ State _____ Country _____

Specialty:_____

From: _____ To: _____
mo./yr. mo./yr.

Completed: ☐ Yes ☐ No

16. Previous Professional Experience-Since Completion of Formal Training

City, State, Country	From Month /Year	To Month/Year	Practice Activity	Insurance Carrier

1. **Include any "moonlighting" activities during residency/fellowship, any military service or other public activity. Also include all locations where professional services were rendered including, but not limited to offices, hospitals, licensed surgicenters, office surgery facilities, emergi-centers, outpatient laboratories and x-ray facilities, etc. Use "Remarks Addendum" if additional space is required. Explain all gaps in professional activities.**
2. **2. Please attach a copy of your current Curriculum Vitae.**

17. Physician Limits: (Please skip this section if you practice in a state with a Patient's Compensation Fund.)

The offering of the following policy limits by ISMIE Mutual should not be deemed to express or imply that any particular policy limit is or is not adequate for an insured. It is the sole responsibility of each insured to select an appropriate limit of coverage.

❑ $200,000/$600,000 "each person"/ "aggregate"	❑ $500,000/$1,500,000 "each person"/ "aggregate"
❑ $1,000,000/$3,000,000 "each person"/ "aggregate"	❑ $2,000,000/$4,000,000 "each person"/ "aggregate"

Medical Specialty Information:

18a. Principal Medical Specialty in which you practice:_____ **18b. % of practice time:** _____

19a. Sub-Specialty in which you practice:_____ **19b. % of practice time:** _____

20a. Currently Held Board Certifications and Dates: _____

20b. Recertification Dates: _____

20c. Do you practice as a Hospitalist? **Yes** ☐ **% of practice time** _____ **No** ☐

(Hospitalist is defined as a physician who is solely based in a hospital and whose primary responsibility is to coordinate the care for hospital inpatients, including the coordination of hospital staff, ordering tests and making treatment decisions in consultation with the patient's attending physician)

20d. Do you provide Concierge services? **Yes** ☐ **% of practice time** _____ **No** ☐

(Concierge medicine, also known as direct primary care, involves charging patients a fee or retainer in exchange for medical care and treatment)

If "yes", please describe the services you provide, hours of availability, etc.

21. Types of Practice Relationships (check all that apply)

☐ **A**. Individual

☐ **B**. Employed
Employer's Name_____

☐ **C**. Independent Contractor **(Please attach copy of contract)**
Contractor Name: _____

☐ **D**. Partner of a medical partnership.
Partnership Name: _____
"Please attach copy of partnership or business agreement"

☐ **E**. Shareholder/member of a medical/ professional service corporation/limited liability company (LLC).
Corporation Name: _____
"Please submit State issued Organizational Documents"

☐ **F**. Sole Shareholder of a Medical / Professional Service Corporation
Corporation Name: _____
"Please submit State issued Organizational Documents"

Does this entity operate under any other names (d.b.a. "doing business as")?
Yes ☐ No ☐
If Yes, list all names: _____
_____

Are separate limits desired for this entity? (Only separate limits available for states with a Patient Compensation Fund).
Yes ☐ No ☐

Please Note: **If separate limits are desired for your Sole Shareholder Corporation, please complete an Application for Partnership/ Corporation/ Clinic Option, which is available on our website- www.ismie.com.**

Coverage for your sole shareholder corporation is available at no additional charge on a shared-limits basis subject to underwriting approval and receipt of State issued Organizational Documents. Coverage for a Sole Shareholder Corporation will not exist unless specifically added by endorsement. (Shared limits for your Corporation are not available in states with Patient Compensation Fund)

*** Please attach a copy of the Independent Contractor Agreement**

22. Please provide census information on physicians who are partners, shareholders, officers, directors, employees or independent contractors. If additional space is required to complete this question, use "Remarks Addendum" section.

Code :	01 - Partner	02 - Shareholder	03 - Officer	04 - Director	05 - Employee	06 - Independent Contractor *

Code		Physician Name	Insurance Carrier	Specialty	Limits of Liability	Policy Number
	1)					
	2)					
	3)					
	4)					
	5)					

23. Allied Health Personnel

Please provide census information on your employed Allied Health Personnel.
Only separate limits are available in states with a Patient Compensation Fund.

Coverage for the following Allied Health Personnel are offered on either a Shared or Separate Limit basis for an additional charge. A separate Non-Physician application is required, and is available on our website- www.ismie.com.

		Total			Total
A .	**Certified Registered Nurse Anesthetist**	**____**	**E.**	**Physician Assistant**	**____**
B.	**Certified Clinical Nurse Specialist**	**____**	**F.**	**Psychologist**	**____**
C.	**Certified Nurse Practitioner**	**____**	**G.**	**Other (Specify Below)**	**____**
D.	**Certified Nurse-Midwife**	**____**			

Coverage for the following Health Care Professionals is only offered on Separate Limit basis for an additional charge. A separate Individual Physician application is required for Chiropractors and Podiatrists, and a Non-Physician application is required for Dentists, Optometrists and Pharmacists. Applications are available on our website- www.ismie.com.

		Total			Total
H.	**Chiropractor**	**____**	**K.**	**Podiatrist**	**____**
I.	**Dentist**	**____**	**L.**	**Pharmacist**	**____**
J.	**Optometrist**	**____**			

Note: Coverage for all Health Care Professionals is limited to the scope of employment and services rendered on behalf of the ISMIE Mutual insured Physician or Corporation.

24. PRACTICE INFORMATION

List all current Office/Outpatient Practice Locations in this section. Include all locations whether or not ISMIE Mutual insurance is desired at that location. Please copy this page for additional locations. Please include facility code(s) to identify all that are applicable.

Facility Codes (Please indicate all that apply)

01- Physician Office
02- Hospital
03- Extended Hour Walk-In Clinic
04- Surgicenter
05- Day Spa/Medi-Spa
06- Nursing Home/Extended Care Facility
07-HMO, IPA, PPO
08-Urgent Care Center
09-Clinic with overnight stays
10-Industrial Clinic
11- Government Location
12-Weight Reduction Clinic
13-Pharmacy
14-Abortion Clinic
15-Drug Control Clinic
16-Commercial Laboratory
17-Other

A. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

B. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

24. PRACTICE INFORMATION (cont'd)

C. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? **Yes** ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

25. Do you have a written contract to provide healthcare services to any professional sports organizations? **Yes** ☐ **No** ☐

If "yes", please provide names of Organization(s) _____
(please include copy of contract)

26.A Do you provide Telemedicine Services? **Yes** ☐ **No** ☐

If "yes", please indicate where the films or other forms of electronic transmissions will be read, i.e. City / State. _____ .

If these transmissions will originate in another state, please provide a copy of your medical license for that state.

26.B Do you perform Robotic Surgery? **Yes** ☐ **No** ☐

If "yes", if please complete the medical procedures questions on pages 9-14, including #34 if necessary.

26.C Do you provide Aesthetic or Spa type services? **Yes** ☐ **No** ☐

If "yes", please complete the medical procedure questions on page 10 and provide narrative if necessary.

27. Have you ever voluntarily given up performing one or more procedures at any of your hospital affiliations? **Yes** ☐ **No** ☐

If "yes", please describe the procedures changed in the Remarks Addendum section of the application.

28. Do you maintain hospital privileges at one or more facilities? **Yes** ☐ **No** ☐

If yes, please complete section A and B (please copy this page for additional hospital locations)
If you do not maintain hospital privileges, please explain in the "Remarks Addendum" section.

A. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes** ☐ **Classroom** ☐ **Clinical** ☐

Do you staff the ER at this hospital other than to maintain hospital privileges?

Yes ☐ **No** ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ **No** ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: **Yes** ☐ **No** ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

Distance from Home: **Miles** _____ **Minutes** _____

B. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes** ☐ **Classroom** ☐ **Clinical** ☐

Do you staff the ER at this hospital other than to maintain hospital privileges?

Yes ☐ **No** ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ **No** ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: **Yes** ☐ **No** ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

Distance from Home: **Miles** _____ **Minutes** _____

29. Minor Risk Procedures (please answer all questions regardless of your medical specialty)

A. Minor Risk Procedures – Interventional Cardiology

Currently Performing: ***Denotes Specified Minor Risk Procedures for Cardiovascular Disease specialists**

Yes	No		
☐	☐	1.	Angiography
☐	☐	2.	Arteriography
☐	☐	3.	Arterial, Venous, Cardiac or other Diagnostic Catheterizations This does not apply to Swan-Ganz, umbilical cord, urethral catheterization or arterial line in a peripheral vessel, which are covered under a specialty designation/risk notation of NMRP
☐	☐	4.	Defibrillation Insertion
☐	☐	5.	Electro-physiological studies and ablations
☐	☐	6.	Insertion of Balloon Expandable Stent
☐	☐	7.	Insertion of Cardiac Pacemaker whether temporary or permanent *
☐	☐	8.	Insertion of intra-aorta balloon pump
☐	☐	9.	Intracoronary Infusions
☐	☐	10.	Myocardial Biopsies
☐	☐	11.	Pericardiocentesis *
☐	☐	12.	Percutaneous Transluminal Therapeutic Angioplasty including placement of stents

B. Minor Risk Procedures - Interventional Radiology

☐	☐	13.	Peripheral arterial angiography, angioplasty, atherectomy, thrombolysis, and stenting
☐	☐	14.	Deep organ biopsy
☐	☐	15.	Nephrostomy
☐	☐	16.	Percutaneous vertebroplasty/kyphoplasty
☐	☐	17.	Percutaneous radiofrequency ablation of deep/superficial tumors
☐	☐	18.	Extracranial embolization procedures(including fibroid embolization, hepatic chemoembolization)

C. Minor Risk Procedures - Ophthalmic Surgery

☐	☐	19.	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, Incision and Curettage
☐	☐	20.	Astigmatic Keratotomy (AK), Automated Lamellar Keratoplasty (ALK), Conductive Keratoplasty (CK), Laser-Assisted in situ Keratomileusis (LASIK), Laser Thermal Keratoplasty (LTK), Photorefractive Keratotomy (PRK), Radial Keratotomy (RK) or Refractive Lens Exchange (RLE) Surgery

29. Minor Risk Procedures (cont'd)

D. Minor Risk Procedures – Other

☐	☐	21.	Assisting in the performance of surgery *
☐	☐	22.	Interstitial Hyperthermia
☐	☐	23.	Ultrasound Hyperthermia (Superficial only)
☐	☐	24.	MRI Guided Focused Ultrasound for Treatment of Uterine Fibroids
☐	☐	25.	Vascular access for Dialysis (Including Tunneled Catheter)

30. Cosmetic Procedures (please answer all questions regardless of your medical specialty)

Currently Performing:

Yes	**No**		
☐	☐	1.	Neurotoxin Injections such as: Botox and Dysport
☐	☐	2.	Short-term Filler Injections such as: Collagen fillers - Evolence, Zyderm and Zyplast and potentially reversible fillers such as: Hyaluronic Acid Fillers - Juvederm Ultra, Juvederm Ultra Plus, Belotero, Perlane, Restylane, Restylane Silk, Voluma, Captique, Hylaform and Elevesse.
☐	☐	3.	Long term Filler Injections that are semi-permanent such as: Artefill, Radiesse and Sculptra
☐	☐	4.	Endovenous Laser Vein Treatment (EVLT)
☐	☐	5.	Laser Treatment of Leg Veins
☐	☐	6.	Skin Treatment performed with Non-Ablative Laser Treatment or Non-Ablative Chemical Peels (epidermis is left intact without full destruction)
☐	☐	7.	Skin Treatment performed with Ablative Laser Treatment or Ablative Chemical Peels (extends through the epidermis with epidermal destruction).
☐	☐	8.	Laser Hair Removal
☐	☐	9.	Non-Invasive Skin Tightening or Fat/Cellulite Reduction procedures (no intravenous sedation or incisions) performed with lasers, ultrasound, radiofrequency or freezing.
☐	☐	10.	Injection Lipolysis (Lipodissolve, Mesotherapy or Kybella injection)
☐	☐	11.	Tumescent Liposuction (local anesthesia only)
☐	☐	12.	Liposuction/Suction Lipectomy (under general anesthesia or intravenous sedation)
☐	☐	13.	Other cosmetic fillers including any products from off-shore or non-authorized distributors : List: _____ _____

30. Cosmetic Procedures (cont'd)

Yes	No		
☐	☐	14.	Other procedures not listed above: List: _____ _____ _____
☐	☐	15.	**Plastic surgery** (such as breast augmentation, abdominoplasty, blepharoplasty, rhinoplasty, face lift, etc.) All specialists other than residency trained Plastic Surgeons or Otorhinolaryngologists (ENT), please list all surgical procedures: _____ _____ _____

If you are an OB/GYNE specialist, a Gynecology Specialist or a Primary Care Physician providing obstetrical or gynecological care, please answer all of the following questions:

31. Obstetrical Procedures

A. Number of **total deliveries** you perform **annually**: _____

B. Of your total annual deliveries, please provide a breakdown of the following:

1. Normal Vaginal Deliveries _____
   (Uncomplicated pregnancy, may include episiotomy and application of outlet/low forceps or vacuum cup)
2. VBACs _____
3. Mid-forceps Delivery, Mid Vacuum _____
4. Cesarean Section (primary, repeat) _____
5. Breech Delivery, Vaginal _____
6. External Version _____
7. Multiple Gestation, Vaginal Delivery _____
8. Version and Extraction, 2nd Twin _____

C. Performance of Home Deliveries: Yes ☐ No ☐

D. Chorionic Villi Sampling: Yes ☐ No ☐

32. Gynecological Procedures

A. Termination of Pregnancy: Yes ☐ No ☐

If "Yes" First Trimester, # **per year** _____

Second Trimester, # **per year** _____

B. Minor Gynecological Procedures. Please indicate the number performed annually:

Amniocentesis	Yes ☐ No ☐	_____
Cervical Conization	Yes ☐ No ☐	_____
D&C (Does not apply to termination of pregnancy)	Yes ☐ No ☐	_____
Endometrial Ablation	Yes ☐ No ☐	_____
LEEP	Yes ☐ No ☐	_____
Essure Sterilization	Yes ☐ No ☐	_____
Co2 Laser of Cervix	Yes ☐ No ☐	_____
Marsupilation of Bartholeum Cyst	Yes ☐ No ☐	_____
Operative Hysteroscopy	Yes ☐ No ☐	_____
Other _____	Yes ☐ No ☐	_____
(Residency trained OB/GYNE physicians are not required to report other procedures in this section)	**TOTAL**	_____ (Annual)

C. Major Gynecological Surgeries. Please indicate the number performed annually:

Anterior/Posterior Repair	Yes ☐ No ☐	_____
Diagnostic Laparoscopy	Yes ☐ No ☐	_____
Fallopian Tube Recanalization	Yes ☐ No ☐	_____
Hysterectomy (with or without salpingo oophorectomy)	Yes ☐ No ☐	_____
Myomectomy	Yes ☐ No ☐	_____
Operative Laparoscopy (includes tubal sterilization)	Yes ☐ No ☐	_____
Ovarian Cystectomy		
Sacrocolpopexy/Sacrospinous		
Vaginal Vault Suspension	Yes ☐ No ☐	_____
Other _____	Yes ☐ No ☐	_____
(Residency trained OB/GYNE physicians are not required to report other procedures in this section)	**TOTAL**	_____ (Annual)

33. Major Risk Procedures (please answer all questions regardless of your medical specialty)

Currently Performing:

Yes	No	Annual # Procedures	Practice Time %		Surgical Procedures
☐	☐			1.	Administration of General Anesthesia, including intubation and Regional Anesthesia
☐	☐			2.	Therapeutic Anesthesia for pain management (spinal nerve blocks, pumps, stimulators, etc.)
☐	☐			3.	Bariatric Surgery for the treatment of Obesity (including Gastric Stapling, Laparoscopic Adjustable Gastric Band - LAP Band), Gastric Bypass Sleeve Resection, Duodenal Switch Procedures) or other similar surgical procedures for the treatment of morbid obesity, obesity or weight reduction
☐	☐			4.	Cardiac Surgery
☐	☐			5.	Colon Surgery
☐	☐			6A.	*General Surgery - No Bariatric Surgery
☐	☐			6B.	*General Surgery - Including Bariatric Surgery (as defined above in number 3) *(General Surgery may include Extensor Tendon Repair)
☐	☐			7.	Hand Surgery a. Hand and Wrist Surgery - _____ % of practice time b. Upper Extremity Surgery, including elbow and shoulder (other than shoulder replacement) - _____ % of practice time c. Shoulder Replacement Surgery Yes ☐ No ☐
☐	☐			8.	Otorhinolaryngology a. Elective Plastic Head and Neck Only - Yes ☐ No ☐ b. Elective Plastic Other Than Head & Neck- Yes ☐ No ☐ c. Traumatic/Pathologic- Yes ☐ No ☐
☐	☐			9.	Intracranial Balloon Embolization
☐	☐			10.	Neurological Surgery **with Intracranial Surgery** (Including Leksell Gamma Radiosurgical Unit)
☐	☐			11.	Neurological Surgery **No Intracranial Surgery** (If yes, please also answer #16)
☐	☐			12.	Organ Transplantation (Other than Corneal Transplants)
☐	☐			13.	Orthopaedic Procedures excluding spine care/surgery. Orthopaedics includes but is not limited to the following: - Open or closed reduction of fractures or dislocations (other than fingers, toes and shoulders) Arthroscopic procedures, joint reconstruction/arthroplasty, musculoskeletal surgical procedures including grafts, repairs, reconstruction or transfers of bone/cartilage/ligament/tendon -Arthrodesis -Epiphysiodesis - Osteotomy - Amputations (other than digital) - Any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to the fracture - Any fracture of the vertebrae that is dislocated and/or involves concomitant injury to the spinal cord or other adjacent or subjacent organs due to the fracture

33. Major Risk Procedures (con't)

Yes	No	Annual # Procedures	Practice Time %	Surgical Procedures
				- 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
☐	☐			14. Plastic Surgery (other than minor skin grafts)
☐	☐			15. Proctologic Surgery (This does not apply to Proctoscopy with or without biopsy)
☐	☐			16. Spinal Surgery (All open procedures on the spine excluding the coccyx and obtaining An Iliac crest bone graft)
☐	☐			17. Liposuction/suction lipectomy (under general anesthesia or intravenous sedation)
☐	☐			18. Tumescent Liposuction (local anesthesia only)
☐	☐			19. Temporomandibular Joint Surgery (Including total replacement, Arthroscopy, Alloplastic Implants or Meniscal Repair Via Plication)
☐	☐			20. Thoracic Surgery
☐	☐			21. Urological Surgery (Including Vasectomy, Adult Circumcision and Therapeutic Cystoscopy _____ **Check here, if you insert penile prostheses**
☐	☐			22. Varicose Vein Surgery(This does not apply to injection sclerotherapy)
☐	☐			23. Vascular Surgery (Includes peripheral other than Varicose Veins)

34. Other Procedures.

Do you perform other procedures which are not indicated? Yes ☐ No ☐
If Yes, please list all other procedures below.

35. Profile Questions.
Include details to each question in the space provided.
If additional space is needed, utilize the "Remarks Addendum".

YES **NO**

☐ ☐ a. Has your professional liability insurance ever been canceled for non-payment, declined, non-renewed, or issued on terms (including, but not restricted to: restrictive endorsements, surcharged premium, other underwriting action etc.)? **(Not Applicable in Missouri)**

☐ ☐ b. Have you treated any patients by means of any therapeutics which could be considered unconventional, experimental, investigational or clinical research that is not within the scope of research protocols approved by the Food and Drug Administration (FDA) or an institutional review board (IRB) (also known as an independent ethics committee (IEC), an ethical review board (ERB) or a research ethics board (REB))? If "Yes", utilize the "Remarks Addendum" on page 19 to provide a full written narrative indicating treatment(s), and provide name(s) and address(es) of sponsoring institution(s) or entity(ies) if applicable.

☐ ☐ c. Have any of your hospital privileges ever been denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or have you ever been subjected to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry?

☐ ☐ d. Have you ever been subjected to probation, suspension, reprimand, censure, sanction or other disciplinary action as a result of any governmental agency, medical or professional society disciplinary or administrative proceedings?

☐ ☐ e. Has membership in any medical society or professional organization ever been denied, suspended, revoked, voluntarily surrendered or accepted on a restricted basis?

☐ ☐ f. Have you ever been convicted of an act committed in violation of any law, statute or ordinance, including a conviction for driving while intoxicated (DUI), excluding other traffic offenses?

☐ ☐ g. Has your license to practice medicine or prescribe controlled substance ever been suspended, revoked, voluntarily surrendered, reprimanded, fined or subjected to probationary terms? If "Yes", indicate which:

☐ ☐ h. Have you ever incurred, become aware of having, or had an allegation made against you of having any illness or physical disability that impairs or potentially could impair your ability to practice medicine or your specialty including but not limited to: alcoholism, substance abuse, mental illness, degenerative diseases of the central nervous system, organic brain disease, convulsive disorders, multiple sclerosis, rheumatoid arthritis, infectious disease, etc.?

☐ ☐ i. Has any malpractice claim or suit been brought against you within the past five (5) years? If "Yes", please complete the Claim Information Supplement for each claim/suit brought against you in the past and submit complete copies of all office/hospital records, summons and complaint, etc.

Certificate(s) of Insurance

36. If your insurance request is accepted, as a service to its insureds ISMIE Mutual can provide evidence of your coverage on an automated basis to a hospital, employer, etc. by issuing a Certificate of Insurance. If you wish to have a Certificate of Insurance issued to a third party, please complete the following:

Name of Certificate Holder

Street Address

City State Zip

Fax:

If the above is a hospital, please check one:

☐ **Medical Director** ☐ **Administrator**

☐ **Medical Staff Office** ☐ **Other** __________

Specific Policy Limits will be printed on Certificate.

Name of Certificate Holder

Street Address

City State Zip

Fax:

If the above is a hospital, please check one:

☐ **Medical Director** ☐ **Administrator**

☐ **Medical Staff Office** ☐ **Other** __________

Specific Policy Limits will be printed on Certificate.

Name of Certificate Holder

Street Address

City State Zip

Fax:

If the above is a hospital, please check one:

☐ **Medical Director** ☐ **Administrator**

☐ **Medical Staff Office** ☐ **Other** __________

Specific Policy Limits will be printed on Certificate.

Name of Certificate Holder

Street Address

City State Zip

Fax:

If the above is a hospital, please check one:

☐ **Medical Director** ☐ **Administrator**

☐ **Medical Staff Office** ☐ **Other** __________

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

ELECTRONIC SIGNATURES ARE PERMISSIBLE IN ILLINOIS PURSUANT TO THE ELECTRONIC COMMERCE SECURITY ACT (5 ILCS 175); AND PURSUANT TO THE UNIFORM ELECTRONIC TRANSACTIONS ACT IN BUSINESS AND COMMERCE CODE CHAPTER 322 IN THE STATE OF TEXAS.

PROXY

By applying for and receiving coverage from ISMIE Mutual Insurance Company, the policyholder/member agrees to grant, assign, and give a proxy to the Board of Directors of ISMIE Mutual Insurance Company or their designee, for purpose of casting a vote at any and all meetings or in any and all instances in which a vote of the policyholders/members is required. It is understood that in the absence of any further action by the policyholder/member, this proxy shall remain valid and binding for the length of time which the policyholder/member shall continue to be a policyholder/member of ISMIE Mutual Insurance Company. It is further understood that on any given issue as to which policyholders/members shall have a right to vote the policyholder/member may, by indicating in writing his, her, or its desire, revoke this proxy for purposes of the issue or matter then pending a vote. In the instance in which the policyholder/member revokes this proxy, he, she, or it may then vote in person or by written proxy at any meeting called for the casting of said vote. At the conclusion of said vote, this proxy, given to the ISMIE Mutual Board of Directors or its designee, shall return to full force and effect and shall continue in full force and effect unless and until the policyholder/member elects to revoke this proxy for purposes of a future issue which may arise.

_____	_____	_____
Applicant's Name (please print)	**Applicant's Signature**	**Date**

REPRESENTATION

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of ISMIE Mutual in considering this application have been omitted. *I agree that this shall be the basis of the policy of insurance requested and that I will notify ISMIE Mutual of any changes contained herein.*

FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DELAWARE APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A person who knowingly and with intent to defraud and insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: 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 state value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 subjects such person to criminal and civil penalties.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, will be sanctioned for each violation with a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty may be increased to a maximum of five (5) years, if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE TO TEXAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

HIPAA DISCLOSURE

ISMIE Mutual Insurance Company and its affiliates shall act as business associates of applicant(s) with respect to the receipt, use and disclosure of protected health information. The Business Associate Agreement is hereby incorporated by reference.

AUTHORIZATION

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, ISMIE Mutual or its duly authorized representative may conduct an inquiry or investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant for this insurance. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, my/their insurance agents or consultants, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physician, any prior insurance carriers and ISMIE Mutual, or its duly authorized representative. I hereby release and discharge the aforementioned providers of information, ISMIE Mutual, its duly authorized review committee from any and all legal liability which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by ISMIE Mutual or its duly authorized representative**.** I authorize ISMIE Mutual or its duly authorized representative to provide information regarding my professional liability history and to issue Certificates of Insurance to those hospitals, managed care entities or other organizations to which I am affiliated or have applied. I consent and agree to the exchange of information regarding my professional liability policy between my present/future employer and ISMIE Mutual or its duly authorized representative. In the event that my insurance premiums are paid by my present/future employer and the practice relationship between myself and my employer is severed at any time during the policy period for any reason, including but not limited to cancellation of my policy, it is agreed that any and all remaining insurance premiums, including any return premium due, as of the severance date of the practice relationship, shall be the property of the employer. Communication regulations require that certain entities, including ISMIE Mutual and its affiliates, obtain written consent to share or distribute policyholder information via regular mail, e-mail, and facsimile. By signing this consent and authorization, you are agreeing to receive promotional notices or solicitation of the availability of goods, services, membership, and opportunities related to the practice of medicine from ISMIE Mutual and its affiliates.

Applicant's Name (*please print*)	Applicant's Signature	Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor to offer insurance to the applicant. A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original. PLEASE NOTE: Email transmission of a completed application or other document is unsecure. ISMIE Mutual is not responsible for any disclosure while the information is in transit. Email submissions may be made to underwriting@ismie.com

Insurance Agent/Producer/Broker (*please print*)	Signature	Date

Claim Information Supplement (please print). In addition to completing this form, please provide a typed, detailed narrative for each open claim, or any claim that has closed with an indemnity payment. Please photocopy this form for additional claims.

1. Patient/Claimant _____
Name Age Sex

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? ☐ Yes ☐ No If "Yes", state _____ / _____
Month Year

4. Name of insurance carrier defending you: _____

5. Policy Number. _____

6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

_____

7. Disposition or current status of claim or suit:

☐ Open - Indicate case value $ _____

- Has carrier indicated desire to settle?

☐ Yes ☐ No

☐ Closed-With no payment made _____

☐ Closed-With payment made. Indicate amount of settlement or award:

a. Your policy $ _____

b. Total (if additional defendants involved) $ _____

----------NEXT CLAIM----------

1. Patient/Claimant _____
Name Age Sex

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? ☐ Yes ☐ No If "Yes", state _____ / _____
Month Year

4. Name of insurance carrier defending you: _____

5. Policy Number: _____

6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

_____

7. Disposition or current status of claim or suit:

☐ Open - Indicate case value $ _____

- Has carrier indicated desire to settle?

☐ Yes ☐ No

☐ Closed-With no payment made _____

☐ Closed-With payment made. Indicate amount of settlement or award:

a. Your policy $ _____

b. Total (if additional defendants involved) $ _____

Remarks Addendum (please print)

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED, OR CONTINUE INFORMATION ON YOUR LETTERHEAD.
PLEASE WRITE LEGIBLY.

Question Number	Remarks