



State Volunteer Mutual Insurance Company

P.O. Box 1065 – Brentwood, Tennessee 37024-1065
Phone 615.377.1999 – WATS 800.342.2239 – FAX 615.370.1343

Medical Professional Insurance Application

Name _____ Applicable Med. License No. _____
Office Address 2323 Lime Kiln Lane Phone 800-939-4436
Louisville, Kentucky 40222

Mailing Address (if different from above) _____ Phone _____

Type of Practice (Check as many as apply)

- Solo, not Incorporated _____
- Solo, my corporation's name is _____
- Member of group practice called _____
- Full-time faculty member of _____
- Resident/ fellow at _____
- Practice under contract with Inspire Medical, Inc. _____
- Employed by _____
- I employ the following physician(s) _____

States in which licensed to practice _____

If you now practice in more than one state, give the percentage of your practice in each _____

Date you began practice at your present professional location _____

Previous locations of practice, including dates _____

Date of Birth _____ Place of Birth _____

State and County Medical Society Memberships _____

Date coverage desired _____

Payment plan desired _____ Advanced Payment Plan (5% Discount) _____ Semiannual _____ Quarterly _____ 0-Monthly _____

Limits requested for Professional Liability Insurance (\$ each medical incident/ \$ annual aggregate)

100,000 / 300,000	2 million / 4 million	6 million/ 8 million	10 million/ 12 million
200,000 / 600,000	3 million/ 5 million	7 million/ 9 million	
500,000 / 1,500,000	4 million/ 6 million	8 million/ 10 million	
X 1 million/ 3 million	5 million/ 7 million	9 million/ 11 million	

If you have your own professional office and desire Office Premises Liability coverage

Square footage of office N/A _____

Type of occupancy _____ Own _____ Rent _____ Lease _____

Name of most recent insurance carrier _____ Termination date of last policy _____

Retroactive date of last policy _____

FOR OFFICE USE ONLY

	Institution And Location	Dates (From / To)
Medical School	_____	_____
Internship	_____	_____
Residencies	Type	
1.	_____	_____
2.	_____	_____
3.	_____	_____

If you graduated from a foreign medical school, are you ECFMG certified? Yes No

INDICATE YOUR MEDICAL SPECIALTY. IF MORE THAN ONE SPECIALTY APPLIES, SHOW THE PERCENTAGE OF TIME IN EACH SPECIALTY

Code		%	Code		%
80	Administrative Medicine	_____	27	Nuclear Medicine	_____
02	Allergy	_____	63	Obstetrics/Gynecology	_____
03	Anesthesiology	_____	29	Occupational Medicine	_____
46	Cardiac Surgery	_____	64	Ophthalmology, major surgery	_____
05	Cardiology	_____	30	Ophthalmology, office practice only	_____
48	Colon and Rectal Surgery	_____	65	Orthopedic Surgery	_____
06	Dermatology	_____	67	Otolaryngology, major surgery	_____
08 X	Emergency Medicine	__100%	32	Otolaryngology, office practice only	_____
09	Endocrinology	_____	33	Pathology	_____
10	Family Practice - no major surgery	_____	34	Pediatrics	_____
53	Family Practice - major surgery	_____	36	Physical Medicine/Rehab	_____
12	Gastroenterology	_____	68	Plastic Surgery	_____
14	General Preventive Medicine	_____	37	Psychiatry	_____
52	General Surgery	_____	40	Public Health	_____
15	Geriatrics	_____	41	Pulmonary Medicine	_____
55	Gynecology-major surgery-no obstetrics	_____	42	Radiology	_____
16	Gynecology-office practice only	_____	43	Rheumatology	_____
17	Hematology	_____	71	Thoracic Surgery	_____
19	Infectious Diseases	_____	73	Urology	_____
21	Internal Medicine	_____	74	Vascular Surgery	_____
25	Nephrology	_____	Other	_____	
26	Neurology	_____		_____	
61	Neurosurgery	_____		_____	

Specialty Society memberships _____

Specialty Board Certifications which you hold _____

Specialties in which you are Board Eligible _____

List all hospitals where you have privileges. Indicate whether you wish us to send verification of insurance to _____

HOSPITAL	CITY/STATE	TYPES OF PRIVILEGES	SEND VERIFICATION (yes/no)
1. _____	_____	_____	No
2. _____	_____	_____	No
3. _____	_____	_____	No
4. _____	_____	_____	No
5. _____	_____	_____	No
6. _____	_____	_____	No

If you are applying for insurance to cover only part-time practice or moonlighting activities, describe the activity and include the number of hours per such activity involves. Emergency Medicine -- hours per month

CHECK ALL PROCEDURES YOU PERFORM AND ANY ITEM THAT APPLIES TO YOUR PRACTICE

- Assist in major surgery on your own patients
- Assist in major surgery on other than your own
- Perform major surgery on your own patients
- Accept major surgery referrals

NOTE: Any surgery under general anesthesia is considered major surgery.

- Administer general anesthesia
- Perform elective cosmetic surgery

- Set simple fractures
- Reduction of fractures and/or dislocations

- Practice in hospital emergency room, other than when called to see your own patient or as a required staff rotation
- Practice in walk-in clinic

- Cardiac catheterization other than Swan-Ganz
- Percutaneous Intraaortic balloon pumping
- Coronary angioplasty

- Prenatal care
- Non-surgical obstetrics
- Caesarian sections
- Tubal ligations
- D&C

Vasectomies

Acupuncture

Angiography

Discography

Arteriography

Phlebography

Lymphangiography

Pneumoencephalography

IVP's

Radiation Therapy

CHECK ALL PROCEDURES YOU PERFORM

WHERE PERFORMED

APPROX. NO. PER YEAR

Elective abortions

Liposuction

Surgery for morbid obesity

Obstetrical deliveries at other than a licensed acute care hospital

Dermabrasion

Radial keratotomy

INDICATE THE NUMBER OF YOUR EXTENDER EMPLOYEES

Number You Employ

None

Nurse Anesthetists

Nurse practitioners

Nurse midwives

Physician's assistants (graduates of recognized programs)

Psychologists

Optometrists

Other extenders (specify) _____

PLEASE CHECK ONLY ONE

I am applying for Extender Employee Professional Liability Coverage for my extender employees (provides a single separate limit coverage for each extender employee and requires additional premium).

I am NOT applying for insurance for my extender employees.

ANSWER EACH QUESTION. FOR ALL "YES" ANSWERS, ATTACH COMPLETE DETAILS ON A SEPARATE

YES/NO

1. Has your LICENSE to practice in any state ever been denied, suspended, revoked, voluntarily surrendered, or subject to probationary terms?
2. Has your LICENSE to prescribe or dispense narcotics ever been denied, suspended, revoked, voluntarily restricted or subject to probationary terms?
3. Has your MEMBERSHIP in any medical society or professional organization ever been denied, suspended, or voluntarily surrendered?
4. Have you ever been the subject of DISCIPLINARY proceedings or reprimand by any administrative agency, medical licensing board, hospital or professional
5. Has your application for hospital staff PRIVILEGES ever been denied or restricted?
6. Have your hospital PRIVILEGES ever been modified, revoked or non-renewed or have you been subject to or disciplinary action?
7. Have PRECEPTOR(S) or assisting physician(s) ever been assigned to any aspect of your practice by a
8. Have you ever had specialty BOARD CERTIFICATION refused or revoked?
9. Have you ever been convicted of a VIOLATION of any law or ordinance other than traffic offenses?
10. Has any hospital, medical society, administrative agency or professional organization ever requested or you to be EVALUATED for an alleged mental condition, alcohol or drug abuse and/or dependency?
11. Have you ever had an ILLNESS OR DISABILITY that impairs or could impair your ability to practice your including but not limited to alcoholism, drug addiction, compulsive disorders, tremors, multiple sclerosis, or rheumatoid arthritis? If YES, the details required on a separate sheet must include the name and of your treating physician.
12. Has any CLAIM OR SUIT for any alleged malpractice ever been brought against you?
13. Has any CLAIM OR SUIT for alleged malpractice ever resulted in a court judgment against you or a settlement by or by an insurance company?
14. Are you aware of any INQUIRY by an attorney representing your patient (other than workers' or accident claims) about medical care you provided, other than those already reported to accepted by your professional liability insurer?
15. Are you aware of any patient or family member who has expressed significant DISSATISFACTION with the medical you provided other than those already reported to and accepted by your professional liability
16. Has your professional liability INSURANCE ever been canceled, non-renewed, declined or issued on special

NOTE TO KENTUCKY RESIDENTS: Kentucky Insurance Regulations require the following warning statement on all applications for insurance: 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I REPRESENT that the statements and answers made herein are true, and make the same for the purpose of inducing the Company to issue the policy for which the application is hereby made. I UNDERSTAND that this entire policy shall be void if, whether before or loss or claim, I willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject

I UNDERSTAND that the professional liability insurance for which I am applying covers only those medical incidents which arise from professional services or peer review services rendered after the retroactive date (generally, the date the first policy takes effect), and then only if such medical incidents are reported to the Company within policy period. I UNDERSTAND that upon termination of a policy, extended reporting (tail) coverage is available for an additional premium which will be waived only if such termination is due to my death, permanent disability or retirement.

I AUTHORIZE all hospitals, past or present medical associates, licensing boards, past or present professional liability insurers, and all other persons or organizations to release information to the Company for the purpose of evaluating my liability risk. I AUTHORIZE the Company to use a copy of this authorization in place of the original. I UNDERSTAND that any such information will be used by the Company solely for underwriting purposes.

Execution of this application by the applicant does not bind the Company to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

Signature of applicant

Date



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SUPPLEMENTAL APPLICATION FOR PRIOR ACTS COVERAGE FOR MEDICAL PROFESSIONAL LIABILITY COVERAGE

If you are desiring to change your professional liability coverage from another claims-made type carrier to you should either arrange to purchase tail coverage from that carrier or make application to SVMIC for prior acts coverage. Without one or the other of these coverages, medical incidents that occurred prior to the initial effective date of SVMIC's policy (if approved) may not be covered under either policy.

In addition to applying for prior acts coverage with SVMIC, it is important that you maintain your option to purchase tail coverage from your current carrier until you have received an official approval letter or declarations page from SVMIC indicating prior acts coverage has been provided: Please note that most insurance carriers require that you notify them of your desire to purchase tail coverage within a limited period of time – usually 30 days from the termination of your policy. Prior Acts Coverage is not granted automatically and requires separate approval from SVMIC.

NAME OF APPLICANT: (please print) _____

Option 1. I am requesting Prior Acts Coverage from SVMIC.

What is the Prior Acts date requested? _____
This generally should be the date stated as the "Retroactive Date" under your current policy. **Please attach a copy of the policy document showing your current retroactive date.**

Option 2. I am not requesting Prior Acts coverage from SVMIC.

By making this selection, it is assumed that you either do not need or desire this coverage, or that you have made arrangements with your current carrier to purchase tail coverage.

This Supplemental Application is being submitted in conjunction with SVMIC's Medical Professional Insurance Application ("Application"), and I certify that I have specifically referred to questions #12, #13, #14, #15 on page 4 of such Application and have fully disclosed any requested claims, suits, incidents or inquires and the details thereof.

SIGNATURE OF APPLICANT: _____ **DATE:** _____
(In order for this application to be considered, ONE of the above Options must be marked indicating your



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CLAIMS DETAIL ADDENDUM

Applicant's Name: (please print) _____

Please supply the following information for each "yes" response to question #12, #13, #14, and #15 on the Medical Professional Liability Application.

Total number of claims, suits, incidents or inquiries _____

Please print or type answers to each of the following questions in detail. If more than one case exists, please photocopy this sheet for each case. **FULL DISCLOSURE OF THE INFORMATION REQUESTED BELOW IS NECESSARY.**

Plaintiff's Name: _____ Insurance carrier involved: _____

Date of occurrence: _____ Date reported: _____ Date closed (if applicable) _____

What is the status of the case? (check one):

Pending	Settled Out Of Court	Found for Plaintiff
Dropped	Dismissed	Found for Defendant

If damages were paid, either by settlement or court award, what was the amount?

Paid on your behalf: \$ _____ Paid by all parties: \$ _____

What is/was your status? (check one): Primary Defendant Codefendant Other

In the space below (attach additional pages(s) if needed), provide detailed information of the following for each case:

A) Provide a brief description of the incident/claim/suit.

B) What were you alleged to have done incorrectly or failed to have done correctly?

C) Provide any other details you feel are pertinent to the case.

D) Identify any other parties who are named in the claim or suit.

Applicant's Signature: _____ Date: _____