



Obstetricians & Gynecologists Liability Insurance Application

DIRECT FORM

Please complete this application and fax it to (305) 402-2999 along with photocopies of the following items:

- ✓ Your active Medical License
- ✓ Board Certification (if any)
- ✓ Your current insurance Declarations Page
- ✓ Your curriculum vitae

OGRRGA

Obstetricians & Gynecologists RRG of America

Please type or legibly print your responses in full. If you need additional room for complete responses, add any extra pages required to accommodate such responses.

Section I: Personal Information

Full Name (with Suffix)	/ / Date of Birth		
Social Security #	Narcotics DEA#	Medical License #	
Home Address (Street)	(City)	(State) (Zip)	() () Home Phone #

Section II: Practice Information

<i>Solo Group Other</i>			
Practice Name	Type of practice (circle one)	Federal Tax ID of practice	
Your position within practice	# of office locations	# of physicians practicing at each location	
Primary Office (Street)	(City)	(State) (Zip)	
() Office #	() Fax #	() Pager #	() Cellphone #
Email Address and/or Website URL	Office Manager		() OM Phone #
Primary Mailing Address (if different from above)			
<i>If you practice in any other locations, please list them on a supplementary page.</i>			
Hours practiced per week - If less than 20, when did you begin practicing part time?			
			# of patients seen per week

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Section III: Coverage Information

Requested Effective Date: / / Retroactive Date: / /

Requested Limits of Liability: (please circle one)

\$250,000 / \$750,000 \$500,000 / \$1.5M \$1M / \$3M

Are you Board Certified?: Yes No If not, are you Board Eligible?: Yes No

Are you currently covered under another professional liability policy for activities outside of those for which you are now requesting coverage?: Yes No (If so, please attach a description of the coverage)

Please list any subspecialties (if applicable): _____

Please list any other states in which you are licensed to practice medicine:

State	License Number	Status (active or inactive)

Please list all of your med-mal insurers for the past ten years, beginning with your most recent insurer:

Name of Insurer	Coverage Type (Occurrence or Claims-Made)	Policy Number	Policy Period

Please describe any major changes in your practice during the last seven years, including any changes in specialty, any procedures which you no longer perform, any hiatus and any office/administrative changes:

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Section IV: Procedures

Please provide the following details pertaining to deliveries performed (if applicable):

Deliveries	# per Year	Prenatal Diagnostics (if applicable)	# per Year
Pregnancies (Total)		Chorionic villus sampling (CVS)	
Deliveries (Total)		Amniocentesis	
Cesarean		▶ How many previously performed?	
Vaginal After Cesarean		Puncture of umbilical cord	
Vaginal		Neonatal Complications (pre-discharge)	# per Year
Using Forceps		Seizures / Trauma	
Using Vacuum Extractor		Infections	
Premature		Hemorrhages	
Postpartum Retention	% of PTs	Describe how postpartum care is secured:	
Outpatient			
Inpatient surv. for 1 night			
Inpatient surv. for 5 nights			
Inpatient surv. for > 5 nights			

Please indicate the annual quantities of the following procedures which you perform:

Procedure	Qty	Procedure	Qty
Abortion in 1 st Trimester		Laparoscopy	
Abortion after 1 st Trimester		▶ Diagnostic	
▶ How many previously performed?		▶ Surgical	
Burch Colpsuspension		Lymphnode Dissection	
Circumcision		ParaVaginal Repairs	
Cold Knife Cone Biopsy		Radical Hysterectomy	
Colporrhaphy (ant / post)		Radical Vulvectomy	
▶ Mesh enhanced or Standard?		Repair of recto-vaginal fistulas	
Dilation & Curettage		Repair of vesico-vaginal fistulas	
Endometrial Ablations		Sacrospinous Fixation Procedures	
Hysterectomy		Staging Procedures for Endometrial Cancer	
▶ Abdominal		Staging Procedures for Ovarian Cancer	
▶ Vaginal		TOT	
▶ Laparoscopic Assisted		Tubal Ligation	
▶ Laparoscopic Supracervical		TVT	
▶ How many previously performed?		Vulvectomy	
Hysteroscopy		▶ Partial	
▶ Operative Hysteroscopy		▶ Total	
Leep Cone Biopsy		▶ How many previously performed?	

Please list other major surgeries performed:

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Section V: Hospital Privileges & Delivery Locations

Please list all hospitals and surgi-centers where you have privileges and any other locations where deliveries are performed. Indicate the percentage of deliveries performed at each location (if applicable):

Name	Location	Privileges	% of Deliveries

Section VI: Education

Medical Schools, Colleges & Universities which you attended:

Name of University	City	State / Country	Dates Attended
			/ / - / /

Note: If any of the above institutions are foreign medical schools and if you are not certified by the Educational Council for Foreign Medical Graduates, please provide more information on a supplementary page.

Internships, Residencies & Fellowships programs which you undertook (include additional sheets as needed):

Name of Facility	Location	Type of Program	Dates Attended
			/ / - / /

Name of Facility	Location	Type of Program	Dates Attended
			/ / - / /

Please list all medical societies, medical associations & professional societies to which you belong:

Section VII: General Information

IMPORTANT NOTE: If you answer "Yes" to any of the questions in this section, please provide an explanation for your answer on page 6 of this application. Make copies of page 6 as needed.

1	Have any of the following been suspended, voluntarily surrendered, revoked, refused, reprimanded, restricted or reduced?: Your license to practice medicine, license to prescribe or dispense narcotics, membership in any professional society or association, privileges for any hospital or board certification.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you ever been investigated for or convicted of sexual misconduct, battery or any other crime other than a traffic offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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5	Have you ever had professional liability insurance declined, canceled, issued with reduced limits, deductibles, special surcharges or any other special terms, or had renewal refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	To your knowledge, is any such action being considered by your current insurer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Are you an employee of, or do you do contract work for, any governmental agency of any type?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Do you participate in any pharmaceutical testing programs? (if so, please specify whether they are FDA approved programs or not)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Do you treat, or review treatment for, jail or prison inmates? (if coverage is to be provided by another carrier, please provide written evidence of such coverage)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Do you engage in any "moonlighting" activities apart from your regular practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Do you use a collection agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If so, does such agency have authority to file a collection suit at its discretion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Do you work in an emergency room? (if so, please attach a supplementary page describing including the institution in which the emergency room is located, the average number of hours practiced in the emergency room per week and, if coverage is to be provided by another carrier, evidence of such coverage)	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Are you certified in radiology?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you take and/or interpret your own X-Rays or other imaging procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If so, does a radiologist over-read your X-Rays?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Do you perform invasive pain management procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14	Will you be purchasing a reporting period extension ("tail" coverage) from your current/previous insurer? (if so, please provide evidence of such coverage)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Claims & Incidents *(If you answer "yes" to question 15 or 16, refer to the instructions on page 7)*

15	Has a claim or other action based on alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If so, has such claim(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16	Do you have knowledge of any claims; potential claims; lawsuits in which you, your employees or any professional associations, corporations or partnerships to which you belong or have belonged may become involved; any injury allegedly arising out of professional negligence which may give rise to a claim; or any request for a patient's medical records?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If so, has such incidents(s) been reported to a prior professional liability insurer?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Section X: Malpractice Claims & Disciplinary Actions

This form must be filled out in its entirety and to the best of the physician's ability. It is understood by the physician that this form will be reviewed by OGRRGA's Underwriting & Risk Management Committee. It is understood by all parties that this form and any information contained herein will be kept 100% confidential at all time. All claims and disciplinary actions in which the physician has been involved must be reported on this form. Please make photocopies as needed.

Type: (circle one)

Disciplinary Action

Claim

Potential Claim (incident)

____/____/____
Date of Incident/Claim notification

Please describe the nature of the incident/claim/action: _____

What was the outcome?:

Dropped by plaintiff

Currently in discovery

Deposed

Settled out of court

If so, what was the settlement amount?: _____

Pending

If so, what is the likely outcome?: _____

Do you have the medical records available for review?

Yes

No

In order to expedite the application review, please attach copies of any available records

Will you be able to discuss this case with OGRRGA?

Yes

No

Additional comments: _____

I hereby affirm that the above information is true and has been completed to the best of my ability. Additionally, I understand that if any of the information is deemed to be untrue or was filled out with the intent to hide information, it may result in a reconsideration of any medical malpractice insurance provided.

Signature

____/____/____
Date

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634 Bird Road, Coral Gables, FL 33146
Office: 866-633-2900 • Fax: 305-402-2999

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Section X: Applicant's Representations and Authorization

I understand that no coverage will be bound until after the carrier has reviewed the completed application and expressed its intention to provide coverage, and such intention has been provided in writing by an authorized representative of the carrier. Acceptance of payment is not an indication of the carrier's intent to provide coverage. If coverage is declined by the carrier, any advance payment will be promptly returned.

The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I authorize the release of my underwriting and/or claim information from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals, to the carrier and its subsidiaries or agents.

IMPORTANT: In some states, it is a crime for any person to knowingly, and with intent to injure, defraud any insurer, file any false or incomplete statement or claim, or provide any misleading information concerning any fact material thereto.

Signature

/ /
Date

Once you have completed this application and signed both page 6 and page 7, please fax the entire application to (305) 402-2999, along with copies of the following items:

- ✓ Your active Medical License
- ✓ Board Certification (if any)
- ✓ Your current insurance Declarations Page
- ✓ Your curriculum vitae

You may also mail the application to address listed below.

If you join OGRRGA your policy will contain the following disclaimer: "This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."