

**QUICK INDICATION SHORT FORM APPLICATION  
PHYSICIANS PROFESSIONAL LIABILITY INSURANCE**

**\*\*We will provide an estimated premium. Actual premium, or insurability, will be based on loss history & practice characteristics**

**APPLICANT INFORMATION**

# Weekly Hrs? \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_

**PRACTICE INFORMATION**

Check each of the following that applies to your practice: \_\_\_ Individual \_\_\_ Group Practice \_\_\_ Partnership \_\_\_ Prof Corp.  
If in a group practice, is the group owned, managed or controlled by any other healthcare entity? \_\_\_ Yes \_\_\_ No

**CURRENT PROFESSIONAL LIABILITY INSURANCE COVERAGE**

Insurer Company: \_\_\_\_\_ Renewal Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

Annual Premium: \$ \_\_\_\_\_ Limits of Liability: \_\_\_ \$1 million/\$3 million \_\_\_ \$2 million/\$4 million Deductible: \$ \_\_\_\_\_

**DO YOU PERFORM SURGERY (see categories - these lists may not be all inclusive)?**

◇ **No Surgery** - perform neither surgery nor obstetrical procedures. Incising of boils and superficial fascia, suturing of minor lacerations, removal of superficial skin lesions by other than surgical excision.

◇ **Minor Surgery** - applies to all general practitioners or specialists, **EXCEPT** those performing major surgery or anesthesiology, who may perform any of the following medical techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), tonsillectomies and adenoidectomies. **Please list types of procedures routinely performed:** \_\_\_\_\_

◇ **Major Surgery** - includes operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen, pelvis or any other operation which because of the condition of the patient or length of circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures, amputations, termination of pregnancy, the removal of any gland or organ (excluding tonsillectomies and adenoidectomies), plastic surgery and any operation done using general anesthesia. \_\_\_\_\_ number per year  
**Please list types of procedures routinely performed:** \_\_\_\_\_

**CURRENT MEDICAL PRACTICE - SURGICAL SPECIALTIES**

**If you answer yes to any question with asterisks (\*\*), please explain fully on your letterhead.**

**Average number of patients seen per week:** \_\_\_\_\_ **Do you perform the following procedures?**

- |  |                             |                              |   |
|--|-----------------------------|------------------------------|---|
| A. Elective cosmetic surgery                             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | percentage of practice: _____%  |
| B. General surgery                                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | **  |
| C. Vaginal deliveries                                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes | # per yr: _____   |
| E. Abortions   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | # pr yr: _____  |
| F. Neonatology   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | percentage of practice: _____%  |
| G. Professional sports medicine                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | ** DO YOU TREAT FEDERAL OR STATE INMATES _____?   |
| H. Angiography/arteriography/<br>Cardiac catheterization | <input type="checkbox"/> No | <input type="checkbox"/> Yes | DO YOU TREAT PATIENTS IN NURSING HOMES _____?   |
| I. Weight-control surgery/drugs                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | HAVE YOU BEEN TREATED FOR ALCOHOL ABUSE _____?<br>ARE YOU A MEDICAL DIRECTOR OF ANY FACILITY _____? |

**CLAIM HISTORY**

Have you had or reported **ANY** Professional Liability claims or Incidents?  No  Yes NUMBER OF CLAIMS \_\_\_\_\_  
(If "Yes," please complete attached claim supplements incident/claim – make extra copies if needed)

**EDUCATION HISTORY**

Date completed Medical School? \_\_\_\_\_ Date completed Residency? \_\_\_\_\_

Additional Training/Fellowships? \_\_\_\_\_

**NARVER ASSOCIATES, INC. P.O. BOX 1509, SAN GABRIEL, CA 91776  
TELEPHONE (626)943-2200 FAX: (626) 299-1010**

## CLAIM INFORMATION

(Make copies for additional claims/incidents)

Patient's Name \_\_\_\_\_  
Date of Incident? \_\_\_\_\_ Date Reported? \_\_\_\_\_ Date Closed? \_\_\_\_\_

Description \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Status: \_\_\_\_\_ Open Claim - Reserve \$ \_\_\_\_\_  
\_\_\_\_\_ Closed Claim - Amount Paid \$ \_\_\_\_\_  
Defense Costs \$ \_\_\_\_\_  
\_\_\_\_\_ Settlement \_\_\_\_\_ Judgment \_\_\_\_\_ Dismissal

Patient's Name \_\_\_\_\_  
Date of Incident? \_\_\_\_\_ Date Reported? \_\_\_\_\_ Date Closed? \_\_\_\_\_

Description \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Status: \_\_\_\_\_ Open Claim - Reserve \$ \_\_\_\_\_  
\_\_\_\_\_ Closed Claim - Amount Paid \$ \_\_\_\_\_  
Defense Costs \$ \_\_\_\_\_  
\_\_\_\_\_ Settlement \_\_\_\_\_ Judgment \_\_\_\_\_ Dismissal

Patient's Name \_\_\_\_\_  
Date of Incident? \_\_\_\_\_ Date Reported? \_\_\_\_\_ Date Closed? \_\_\_\_\_

Description \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Status: \_\_\_\_\_ Open Claim - Reserve \$ \_\_\_\_\_  
\_\_\_\_\_ Closed Claim - Amount Paid \$ \_\_\_\_\_  
Defense Costs \$ \_\_\_\_\_  
\_\_\_\_\_ Settlement \_\_\_\_\_ Judgment \_\_\_\_\_ Dismissal

**PLEASE FORWARD WITH A COPY OF YOUR CURRICULUM VITAE (CV)**

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