



# Physicians & Surgeons Professional Liability Application

## NEW BUSINESS ENTITY

Mailing Address:

6859 South Eastern Avenue, Suite 103, Las Vegas, Nevada 89119  
Telephone: 702-697-6400 or Toll-Free 866-940-6526  
Facsimile: 702-697-6401 E-mail: info@ind-insurance.com  
Web Site: www.ind-insurance.com

**PLEASE RETURN THIS COMPLETED APPLICATION,  
INCLUDING REQUESTED ATTACHMENTS, TO  
YOUR BROKER**

If a question is not applicable indicate N/A

**AN INCOMPLETE APPLICATION MAY DELAY  
PROCESSING**

Broker: \_\_\_\_\_  
Address: Street \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Fax # \_\_\_\_\_  
E-Mail \_\_\_\_\_

**In addition to this application, each physician must complete an individual New Business application.**

Requested Effective Date of Coverage: \_\_\_\_\_

Please submit the following items with this application:  Carrier Loss Runs (past 10 years)  
 Copy of Declarations Page (current policy)

### 1. Business Entity Information

Legal Business Entity Name: \_\_\_\_\_

Fictitious Firm Name ("d/b/a") as filed with the County Clerk's Office: \_\_\_\_\_

IRS Tax No.: \_\_\_\_\_ Date legal entity was formed: \_\_\_\_\_

A. Primary Practice Location\* (To be used on the policy and all legal notices):

Street \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-Mail \_\_\_\_\_

How many years at this location? \_\_\_\_\_

B. Additional Practice Location\*:

Street \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-Mail \_\_\_\_\_

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Do you have additional practice locations? Yes  No  If yes, list the additional locations on a separate page.

**\*If the entity has been located at these addresses less than a total of ten (10) years, provide additional practice location history for at least ten (10) years on a separate page.**

- C. Preferred Mailing Address (To be used for general correspondence and invoices): Indicate A or B \_\_\_\_\_  
If different than A or B, enter the alternate address below.

Street \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-Mail \_\_\_\_\_

**2. Claim Information**

- A. Has any claim or suit for any alleged malpractice been brought against the Business Entity and/or any physician owner, employee, contractor and ancillary employee in the past ten (10) years? Yes  No   
**If yes, complete a Prior Claim Addendum for each claim or suit.**
- B. Have all incidents, claims or suits relating to and/or occurring at or on behalf of the Business Entity been reported to the current and prior insurers? Yes  No  If no, please explain in Section 7 or on a separate sheet.
- C. Do you know of any circumstances, such as those listed below, that could lead to a claim or suit against the Business Entity, even if such a suit is without claim or merit? Yes  No
1. A letter or notice from an attorney about the medical treatment of a patient performed by anyone employed and/or contracted with the entity? Yes  No
  2. A request for records from a patient/attorney related to an adverse outcome? Yes  No
  3. Complications during or after surgery resulting in death, paralysis or other significant disabilities? Yes  No
  4. Are there any other circumstances or events that might reasonably lead to a claim or suit? Yes  No

**If yes to any of the above, complete a Prior Claim Addendum for each incident.**

5. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? Yes  No
- a. If yes, how many: \_\_\_\_\_ **Attach documentation and/or explanations of all such reports.**
  - b. If no, explain in Section 7 of this application.

**NOTE: YOU MUST REPORT ALL INCIDENTS, CLAIMS OR SUITS DESCRIBED ABOVE TO THE CURRENT INSURERS.**

**3. Prior Insurance Information**

- A. Name of current insurer \_\_\_\_\_ Policy number \_\_\_\_\_  
Type of Coverage: Occurrence  Claims-Made  Limits \_\_\_\_\_

**If Claims-Made, indicate retroactive date of coverage and include a copy of the Declarations Page.**

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Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

B. Name of previous insurer \_\_\_\_\_ Policy number \_\_\_\_\_

Type of Coverage: Occurrence  Claims-Made  Limits \_\_\_\_\_

If Claims-Made, indicate retroactive date of coverage \_\_\_\_\_

Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

C. Name of previous insurer \_\_\_\_\_ Policy number \_\_\_\_\_

Type of Coverage: Occurrence  Claims-Made  Limits \_\_\_\_\_

If Claims-Made, indicate retroactive date of coverage \_\_\_\_\_

Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

**D. Please submit a copy of the policy Declarations for all policies extending back to the date requested for retroactive coverage.**

**4. Claims-Made Coverage**

A. Requested Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

B. Is Retroactive (Nose) Coverage requested? Yes  No  Retroactive date \_\_\_\_\_

C. Limits of Liability desired:

Note: The Limits of Insurance for Coverage B must be the same as the Limits of Insurance requested for each Physician under Coverage A.

Coverage A - Individual Limits of Insurance:

**Each Medical Incident Limit/Individual Professional  
Liability Aggregate Limit**

\$1,000,000 / \$3,000,000

\$2,000,000 / \$4,000,000

\$2,000,000 / \$6,000,000

\$3,000,000 / \$6,000,000

Coverage B - Business Entity Limits of Insurance:

**Each Business Entity Incident Limit/Partnership, Limited  
Liability Company, Association or Corporation  
Professional Liability Aggregate Limit**

\$1,000,000 / \$3,000,000

\$2,000,000 / \$4,000,000

\$2,000,000 / \$6,000,000

\$3,000,000 / \$6,000,000

**Note: The Business Entity limits apply per incident and in the aggregate per policy period regardless of the number of covered physicians, number of Business Entities or number of claims.**

**5. Nature of Group Practice:**

A. Are you practicing as a: (select one) Partnership  Domestic Professional Corporation  Limited Liability Company  Association  Other \_\_\_\_\_

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1. Is Retroactive Coverage requested for the Business Entity? Yes  No 
  - a. If yes, what is your Business Entity Retroactive Date \_\_\_\_\_
  - b. For your entity, do you want a shared or separate limit of insurance? \_\_\_\_\_
2. Is 100% of your practice generated in Nevada? Yes  No  If no, list what portion is outside of Nevada and in what other states are you practicing: \_\_\_\_\_
- B. How many patients does your practice see per week? \_\_\_\_\_
- C. Has the nature of the Entity's practice changed in the past five (5) years? Yes  No   
If yes, please explain: \_\_\_\_\_
- D. Do you use ExplainMySurgery.com to facilitate Informed Consent? Yes  No
- E. Miscellaneous Information (for all "Yes" answers, provide an explanation in Section 7 – Additional Information. Attach a separate sheet if necessary.)
  1. Do you maintain an outpatient surgical facility? Yes  No  Legal Name \_\_\_\_\_  
If yes, do you currently have a separate Medical Professional Liability Policy written in the name of the surgical facility? Yes  No  If no, explain \_\_\_\_\_  
Name of Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
**Please attach a copy of the most current Declarations Page for the separate Policy.**
  2. Has your Partnership, Corporation, Limited Liability Company or Association ever been investigated by any State Board of Medical Examiners, State Licensing Authority, the DEA or any state or federal governmental agency? Yes  No   
**If yes, explain and forward a copy of any Inquiry, Accusation, Complaint or Decision.** \_\_\_\_\_
  3. Do you manufacture, sell or distribute any drug, pharmaceutical, medical device or other product to persons other than patients of your Business Entity and your physicians? Yes  No   
If yes, describe the product or the activities of your Business Entity. \_\_\_\_\_
  4. Does your Business Entity own any other Entity? Yes  No  or is your Business Entity under common ownership or the control of any other Business Entity? Yes  No  If yes, explain: \_\_\_\_\_
  5. Has any insurance company canceled, refused renewal, declined coverage or modified coverage (i.e. reduced limits, assigned a deductible, restricted coverage or surcharged rates)? Yes  No  If yes, explain: \_\_\_\_\_

<b>6. Professional Employees</b>
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- A. Employed Physicians and Surgeons? Yes  No

Name	Specialty	Insurer	Hire Date

**If IND is not providing coverage for these physicians, you must provide proof of other coverage and a copy of their Nevada medical license.**

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B. Contracted Physicians and Surgeons? Yes  No

Name	Specialty	Insurer	Hire Date

**If IND is not providing coverage for these physicians, you must provide proof of other coverage and a copy of their Nevada medical license.**

C. Employed and/or Contracted Physician Assistants, CRNA's, Nurse Midwives (Including Certified and Direct-Entry), Nurse Practitioners, Nurses or Technicians? Yes  No

Name	Technical Employee Type	Hire Date

Do any of the above employees function without direct physician supervision? Yes  No  If yes, please explain:

**A copy of the technical employee's license and/or certificate must be submitted.**

D. Employed administrative personnel? Yes  No

Administrative Employee Type	Number	Administrative Employee Type	Number

E. Do the employees identified in A, B or C maintain separate liability coverage? Yes  No

**7. Additional Information**

Please provide us with any additional information you may wish us to consider with your application. For example you may wish to more fully describe your practice than as outlined in this application.

**THIS APPLICATION MUST BE SIGNED IN INK BELOW.**

**I hereby warrant that the information contained in this application is accurate and complete to the best of my knowledge. Any occurrence or event that takes place prior to the issuance of the policy applied for, and which may render any statement made herein inaccurate, untrue or incomplete, will be immediately reported in writing to Independent Nevada Doctors Insurance Exchange (IND). I acknowledge and agree that the submission and IND's receipt of such written report, prior to the inception of the policy applied for, is a condition precedent to coverage.**

**I further represent that I am not aware of any fact, circumstance or situation from a medical incident indicating the probability of a claim or suit for which coverage is or would be afforded by the insurance for which application is now being made. It is understood that this coverage will not apply to any claim or**

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suit that arises out of any fact, circumstance or situation that is known to any insured prior to the effective date of this policy if a reasonable physician or other person would have foreseen that such circumstances would result in a claim or suit against any insured.

The signing of this application does not bind me to purchase the insurance, nor does review of the application bind IND to issue a policy.

I acknowledge that receipt or negotiation of a check, cashier's check, money order or other form of payment by IND does not constitute acceptance of my application and is not an agreement by IND to bind, renew or reinstate coverage. I understand coverage will be bound, renewed or reinstated only when I have received written notice of such binding, renewal or reinstatement from IND.

I understand that this application shall be considered a part of the terms and conditions of my insurance policy with IND if a policy is issued.

I acknowledge and agree that I have been provided copies of or access at [www.ind-insurance.com](http://www.ind-insurance.com) to the following documents: Subscribers' Agreement and Power of Attorney and Governance Rules (collectively referred to as "the Documents"). If I am accepted for coverage, as a subscriber of IND, I acknowledge and agree that I will be subject to all of the provisions of the Documents and hereby agree to appointment of Index Managers, Inc. as the attorney-in-fact for IND.

I acknowledge that I was advised that I may retain an attorney at law to review this application and the Documents.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature