



**INDEPENDENT NEVADA DOCTORS INSURANCE EXCHANGE  
Physicians & Surgeons Professional Liability Application  
NEW BUSINESS**

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B. Additional Practice Location (if more than 1 provide information on separate page):

Street \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-Mail \_\_\_\_\_  
How many years at this location? \_\_\_\_\_

C. Home Address:

Street \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-Mail \_\_\_\_\_  
How many years at this location? \_\_\_\_\_

D. Preferred Mailing Address (if different from Home Address):

Street \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-Mail \_\_\_\_\_  
How many years at this location? \_\_\_\_\_

E. Nevada Licensure

1. Nevada License # \_\_\_\_\_ Date granted \_\_\_\_\_ Date expires \_\_\_\_\_
2. Is it a full license? Yes  No  If no, explain. \_\_\_\_\_
3. Is it a limited license? Yes  No  If yes, explain. \_\_\_\_\_

F. Other State Licensure

List any other states in which you are licensed:

1. State \_\_\_\_\_ License # \_\_\_\_\_  
Date granted \_\_\_\_\_ Date expires \_\_\_\_\_
2. State \_\_\_\_\_ License # \_\_\_\_\_  
Date granted \_\_\_\_\_ Date expires \_\_\_\_\_

G. Additional information

1. Has your Nevada (or any other) state license to practice medicine ever been refused, suspended, revoked or voluntarily surrendered? Yes  No  If yes, explain.  
\_\_\_\_\_
2. Have you been subject to any disciplinary action by any state Board of Medical Examiners and/or other licensing authority? Yes  No  If yes, explain.  
\_\_\_\_\_
3. Are you now subject to an ongoing investigation by any state Board of Medical Examiners and/or other license authority? Yes  No  If yes, please provide a copy of the filed complaint.
4. Have you ever been diagnosed with or professionally advised to seek treatment for alcohol or drug abuse or addiction, or mental illness? Yes  No  If yes, explain.  
\_\_\_\_\_

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5. Have you ever been charged with or convicted of a drug offense? Yes  No  If yes, explain.

\_\_\_\_\_

6. Have you ever been charged with or convicted of a criminal offense other than a minor traffic violation? Yes  No  If yes, explain.

\_\_\_\_\_

**2. Education**

A. College or University:

1. Name of School \_\_\_\_\_  
Location \_\_\_\_\_ Degree \_\_\_\_\_  
Year(s) Attended \_\_\_\_\_ Year Graduated \_\_\_\_\_

2. Name of School \_\_\_\_\_  
Location \_\_\_\_\_ Degree \_\_\_\_\_  
Year(s) Attended \_\_\_\_\_ Year Graduated \_\_\_\_\_

B. Medical School:

1. Name of School \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Year(s) Attended \_\_\_\_\_  
Degree \_\_\_\_\_ Year Graduated \_\_\_\_\_

2. Name of School \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Year(s) Attended \_\_\_\_\_  
Degree \_\_\_\_\_ Year Graduated \_\_\_\_\_

3. If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? Yes  No

If yes, provide USMLE/ECFMG Identification Number: \_\_\_\_\_

Date Certificate Issued: \_\_\_\_\_ Date Certificate Expires: \_\_\_\_\_

If no, explain. \_\_\_\_\_

C. Post-Graduate Training

List all internships, residencies and fellowships in the order in which they were started. If not completed, please attach a page with an explanation.

1. Institution \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Specialty \_\_\_\_\_  
Type of training \_\_\_\_\_ Dates From \_\_\_\_\_ and To \_\_\_\_\_

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2. Institution \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Specialty \_\_\_\_\_  
Type of training \_\_\_\_\_ Dates From \_\_\_\_\_ and To \_\_\_\_\_

**D. Specialty Board Certifications**

List the names of the specialty boards of which you are a member.

1. Board Name \_\_\_\_\_  
Are you certified? Yes  No  If yes, year certified \_\_\_\_\_  
Are you re-certified? Yes  No  If yes, year re-certified \_\_\_\_\_

2. If you are not certified, are you board eligible? Yes  No   
How many times have you taken the exam for certification? \_\_\_\_\_  
If yes, when do you anticipate completing the boards? \_\_\_\_\_

**E. Professional and Medical Society Memberships**

1. Local

a. Name \_\_\_\_\_  
Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

b. Name \_\_\_\_\_  
Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

2. State

a. Name \_\_\_\_\_  
Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

b. Name \_\_\_\_\_  
Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

3. National

a. Name \_\_\_\_\_  
Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

b. Name \_\_\_\_\_  
Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_

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**3. Claim Information**

- A. Has any claim or suit for any alleged malpractice been brought against you in the past ten (10) years? Yes  No  **If yes, please complete a Prior Claim Application Addendum for each claim or suit.**
- B. Have you reported all incidents, claims or suits to your current and prior insurers? Yes  No  (If no, please explain on a separate sheet.)
- C. Do you have any knowledge of any incidents in the past which may give rise to a claim being filed in the future which has not been reported to any previous insurance carrier? Yes  No  **If yes, please complete a Prior Claim Application Addendum for each incident.**

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

**4. Prior Insurance Information**

- A. Name of previous insurer \_\_\_\_\_ Policy number \_\_\_\_\_  
Type of Coverage:  Occurrence  Claims-Made Limits \_\_\_\_\_  
If Claims-Made, indicate retroactive date of coverage if provided by prior insurer \_\_\_\_\_  
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 if provided by prior insurer \_\_\_\_\_  
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 if provided by prior insurer \_\_\_\_\_  
Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_
- D. Please submit a copy of the Declarations Page for policies extending back to the date requested for retroactive coverage.

**5. Physician Classification**

- A. Please check ALL SPECIALTIES that apply:

Anesthesiology

Dermatology

Emergency Medicine

Family Physician / General Practice:  No surgery  Surgery

Yes  No  Does your practice includes obstetrics?

If yes, indicate how many deliveries you perform each year: \_\_\_\_\_

Gynecology (excluding obstetrics):  No surgery  Surgery

Hospitalist

Intensive Care Medicine

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Internal Medicine:  No surgery  Surgery

Subspecialty, if any:

- Allergy
- Cardiovascular Disease
- Endocrinology
- Gastroenterology
- Geriatrics
- Hematology
- Infectious Disease
- Nephrology
- Oncology
- Pulmonary
- Rheumatology

Neonatology

Neurology

Nuclear medicine

Obstetrics/Gynecology – Indicate how many deliveries you perform each year: \_\_\_\_\_

Ophthalmology:  No surgery  Surgery

Orthopedics:  No surgery  Surgery

Yes  No  Does your practice include spinal surgery?

Otorhinolaryngology  No surgery  Surgery

Yes  No  Does your practice include plastic surgery?

Pain Management (Pain Management Application Addendum must be completed)

Pathology

Pediatrics

Perinatology – Indicate how many deliveries you perform each year: \_\_\_\_\_

Physiatry

Psychiatry

Radiology:

Describe:  Non-invasive  Major invasive  Minor invasive  Therapeutic Radiation

Yes  No  Does your practice include diagnostic radiology?

Yes  No  Do you provide diagnostic radiology services related to breast cancer?

Yes  No  Do you diagnose other cancers?

Yes  No  Do you provide teleradiology services? If yes, indicate for whom: \_\_\_\_\_

Yes  No  Do you provide teleradiology services for any hospital, laboratory or clinic which is located outside the State of Nevada? If yes, list each state and the percentage of your work from each state: \_\_\_\_\_

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Surgery:

- Abdominal
- Bariatric
- Cardiac
- Cardiovascular
- Colon and rectal
- General
- Hand
- Head and neck
- Neurosurgery
- Plastic/Reconstructive
- Thoracic
- Traumatic
- Urology
- Vascular
- Other \_\_\_\_\_

Yes  No  Does your practice (as indicated above) involve liposuction? (If yes, Liposuction Application Addendum must be completed)

Yes  No  Does your practice (as indicated above) involve sex change operations?

Yes  No  Does your practice (as indicated above) involve phalloplasty for cosmetic purposes?

Urgent Care (not emergency care)

Yes  No  Do you practice in an urgent care facility?

Other (describe) \_\_\_\_\_

B. Please check ALL PROCEDURES that apply:

Acupuncture – other than acupuncture anesthesia

Angiography

Arteriography

Anesthesia:

Yes  No  General

Yes  No  Nerve Block

Yes  No  Spinal/Caudal

Yes  No  Local

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- Catheterization – arterial, cardiac or diagnostic – other than (1) the occasional emergency insertion of pulmonary wedge, pressure recording catheters or pacemakers, (2) urethra catheterization or (3) umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen:  
Yes  No  Right Heart  
Yes  No  Left Heart
- Chelation Therapy
- Cosmetic/Plastic Surgery:  
Yes  No  Minor  
Yes  No  Major  
Yes  No  Botox Injections  
Yes  No  Chemical Peels  
Yes  No  Hair Transplants  
Yes  No  Scar Revisions  
Yes  No  Sclerotherapy  
Yes  No  Silicone Injections
- Colonoscopy
- Cryosurgery – other than use on benign or pre-malignant dermatological lesions
- Discograms
- Endoscopic retrograde cholangiopancreatography (ERCP)
- Endoscopy
- Lasers – used in therapy
- Lymphangiography
- Myelography
- Needle Biopsy – including lung and prostate but not including liver, kidney or bone marrow biopsy
- Phlebotomy
- Pneumatic or mechanical esophageal dilation (not with bougie or olive)
- Pneumoencephalography
- Radiation Therapy
- Radiopaque Dye – injections into blood vessels, lymphatics, sinus tracts of fistulae
- Shock Therapy
- Sigmoidoscopy
- Weight Management (Weight Management Application Addendum must be completed)
- X-Ray:  
Yes  No  Diagnostic  
Yes  No  Therapeutic Radiation  
Yes  No  Ultrasound

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C. OTHER INFORMATION:

Yes  No  Do you research, use, administer, or prescribe any drug, pharmaceutical or medical device disapproved or not yet approved for marketing by the United States Food and Drug Administration for treatment of human beings (including any FDA approved studies/investigations)? If yes, please describe: \_\_\_\_\_

Yes  No  Do you provide any direct patient treatment during child delivery (including the immediate labor, puerperium, and/or neonatal period) at a facility other than a licensed acute care hospital? If yes, please describe: \_\_\_\_\_

Yes  No  Do you render emergency room care other than to your own patients? If yes, indicate approximate number of hours per week: \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

**6. Claims-Made Coverage**

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

B. Is Retroactive (Nose) Coverage requested? Yes  No  If yes, date to begin \_\_\_\_\_

C. Limits of Liability desired:

Coverage A - Individual Limits of Insurance:  
\$1,000,000 Each Medical Incident Limit  
\$3,000,000 Individual Professional Liability Aggregate Limit

Coverage B - Business Entity Limits of Insurance:  
\$1,000,000 Each Business Entity Incident Limit  
\$3,000,000 Partnership, Limited Liability Company, Association or Corporation Professional Liability Aggregate Limit

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. There is no Business Entity coverage relating to any physicians for which coverage is not provided. If the Business Entity is solely owned, the limits of liability for the covered physician and Business Entity are shared limits.

**7. Nature of Practice:**

A. Are you practicing as: (select one)

An individual?

An employed physician? Name of Employer: \_\_\_\_\_

A partner or stockholder of a:  Partnership?  Limited Liability Company?

Association?  Professional Corporation?

Name of Partnership, Limited Liability Company, Association or Professional Corporation:  
\_\_\_\_\_

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B. List all Physician Partners or Stockholders: (indicate if you are the sole owner)

Name	Specialty	Insurer

1. As a sole owner, do you want the entity covered on the policy? Yes  No

2. Is Retroactive Coverage requested for the entity? Yes  No

If yes, what is your entity Retroactive Date \_\_\_\_\_

Explain if date indicated above is different than your requested individual Retroactive Date: \_\_\_\_\_

3. 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: \_\_\_\_\_

C. How many hours per week do you practice? \_\_\_\_\_

D. How many patients do you see per week? \_\_\_\_\_

E. Do you act as a Medical Director for any organization? Yes  No  If yes, please list: \_\_\_\_\_

F. Do you practice as a full-time *Locum Tenens* physician? Yes  No

G. Has the nature of your practice changed significantly in the past five (5) years? Yes  No  If yes, please explain: \_\_\_\_\_

H. Hospital Affiliations (at which hospitals do you have privileges)

1. Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Nature of Privileges \_\_\_\_\_

Are your privileges restricted or provisional? \_\_\_\_\_

Dates From \_\_\_\_\_ and To \_\_\_\_\_

2. Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Nature of Privileges \_\_\_\_\_

Are your privileges restricted or provisional? \_\_\_\_\_

Dates From \_\_\_\_\_ and To \_\_\_\_\_

I. Other Affiliations

List all other affiliations with clinics, entities, and offices not already addressed above. Military experience should also be included.

1. Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Specialty \_\_\_\_\_

Dates From \_\_\_\_\_ and To \_\_\_\_\_

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2. Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Specialty \_\_\_\_\_  
 Dates From \_\_\_\_\_ and To \_\_\_\_\_

**8. Professional Employees**

Does your practice (or that of your partnership, limited liability company, association or corporation) include any of the following:

A. Employed Physicians and Surgeons? Yes  No

Name	Specialty	Insurer

If the Exchange is not providing coverage for these physicians, you must provide proof of other coverage.

B. Contracted Physicians and Surgeons? Yes  No

Name	Specialty	Insurer

If the Exchange is not providing coverage for these physicians, you must provide proof of other coverage.

C. Employed Physician Assistants, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, Nurses or Technicians? Yes  No

Technical Employee Type	Number	Technical Employee Type	Number
Physician Assistants		Nurses (Registered or Licensed Vocational)	
Physician Assistants-Certified		Technician(s) – Type: _____	
Nurse Anesthetists		Technician(s) – Type: _____	
Nurse Midwives		Other: _____	
Nurse Practitioners		Other: _____	

Do any of the above employees function without direct supervision of the physician? Yes  No

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

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**9. 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.

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**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 the Exchange. I acknowledge and agree that the submission and the Exchange'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 suit that arises out of any fact, circumstance or situation that is known to the insured prior to the effective date of this policy if a reasonable physician would have foreseen that such circumstances would result in a claim or suit against the insured.

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

I understand that this application shall be considered a part of the terms and conditions of my insurance policy with the Independent Nevada Doctors Insurance Exchange (IND) if a policy is issued.

\_\_\_\_\_ [Applicant's Initials] 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.

\_\_\_\_\_ [Applicant's Initials] 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