



Anesthesiologists' Professional Assurance Company

# Application

***FOR  
PROFESSIONAL LIABILITY INSURANCE  
FOR THE PRACTICE OF  
ANESTHESIOLOGY AND/OR PAIN MANAGEMENT***

Medical Professional Liability Insurance Policy  
Claims-Made  
Non-Assessable

**Home Office:**

Anesthesiologists' Professional Assurance Company  
1000 Riverside Avenue, Suite 800  
Jacksonville, Florida 32204  
1-866-294-6014

FAX: 904-358-6728  
www.apacinsurance.com

**Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any applicable endorsements, has been issued to the named insured.**

**Help us expedite the processing of your application:**

- Please print your responses in ink or type.
- Answer every question or mark it "not applicable" (N/A).
- Use the "Remarks" section to amplify your answers, where requested (see #38).
- If you have had claims, incidents or suits filed against you, please make certain you have completed a Claims Information form for each claim or suit in the past fifteen (15) years. (See page 10.)
- Signatures required on pages 9 and 10.
- Copy of your CV/Résumé, Office Letterhead and Current Declarations Page
- Incomplete answers and/or missing attachments **will** delay our processing of the application.



Anesthesiologists' Professional Assurance Company

1. If my application is approved, make coverage effective at 12:01 a.m. on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ with a retroactive date of \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

2. Name: \_\_\_\_\_  MD  DO (Check One)
First Middle Last

3. Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ í Male í Female

4. Social Security Number: \_\_\_\_\_

5. List all medical license numbers:

Table with 4 columns: a, b, c, d. Each column has sub-headers: State, Lic. #, Status.

Please use Remarks #38 if additional space is needed.

6. Primary Practice Address:

Table with 6 columns: Number, Street, City, State, Zip, % of Practice time at this location. Row 2: Telephone #, Fax #, E-Mail Address.

7. List additional practice locations including all offices, surgical centers and other non-hospital locations.

Table with 6 columns: Type of Practice, Number, Street, City, State, Zip, % of Practice time at this location. Row 2: Telephone #, Fax #, E-Mail Address.

Please use Remarks #38 if additional space is needed.

8. Scope of Coverage:

I do not want coverage under this policy for the part of my medical practice listed below.

Table with 3 columns: Practice Name, Address, Start Date (mm/dd/yy) - End Date (mm/dd/yy).

Please use Remarks #38 if additional space is needed.

9. Home Address: \_\_\_\_\_ ( ) \_\_\_\_\_
Number Street Telephone
City State Zip Fax

10. Mailing Address (choose one):  Home  Primary Address (see question #6)
 Other (specify) \_\_\_\_\_



**17. Changes in Practice**

- a. Have you practiced continuously for the past ten (10) years?  YES  NO  
If **No**, please explain in Remarks #38
- b. Have your practice procedures, specialty, location(s), etc., changed in the past ten (10) years  YES  NO  
If **Yes**, please explain noting dates of changes: \_\_\_\_\_
- c. Are you a military physician?  YES  NO  
If **Yes**, is/was your military obligation in remuneration for medical school tuition?  YES  NO

**18. Specialty Societies** - List all specialty societies of which you are a member:

\_\_\_\_\_

\_\_\_\_\_

**19. Please check all that apply:**

- a. Are you a member of your state medical society?  YES  NO
- b. Are you a member of your state specialty society?  YES  NO

**20. Prior Insurance**

Insurance history for the previous fifteen (15) years:

Coverage Period From / To Mo./Yr. Mo./Yr	Insurance Carrier	Policy #	Type of Policy Claims-Made/Occurrence	Retroactive Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**21. Insurance**

- a. Have you **ever** practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage?  YES  NO
- b. Have you **ever** had professional liability insurance refused, declined, non-renewed cancelled or accepted on special terms?  YES  NO
- c. Have you **ever** been required to pay a premium surcharge or have you ever been involved in an appeal concerning the imposition of such a surcharge?  YES  NO  
If **Yes** to a, b or c, please explain in Remarks #38.

**22. Limits of Liability** (Please check the desired limits of liability)

- \$250,000 per claim/\$750,000 aggregate per single policy year
- \$500,000 per claim/\$1,500,000 aggregate per single policy year
- \$1,000,000 per claim/\$3,000,000 aggregate per single policy year
- Other: \_\_\_\_\_

Optional coverages:

- a. Do you desire license investigation defense coverage for ALL investigations? \*  YES  NO
- b. Do you desire Mededense (Medicare/Medicaid Fraud & Abuse) coverage? \*  YES  NO

NOTE: Option b. is only available if option a. is selected.

\* In Florida our Broad Form Investigation Defense Coverage includes these coverages and others at no additional charge.

**23. Prior Acts**

If your expiring policy is on a Claim-Made basis, an extended reporting period endorsement "tail" is generally available as an option of your expiring Claims-Made policy.

- a. Are you exercising this option?  YES  NO
- b. If **NO**, do you want us to provide coverage for prior acts (claims or incidents, which may have occurred but, as yet, no indication has been made to you)? *(If Yes, please attach a copy of your current Declarations page.)*  YES  NO
- c. Indicate reason for termination of latest policy: \_\_\_\_\_

***Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.***

**24. Have you ever:**

- a. been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, nonrenew or revoke your privileges?  YES  NO
- b. had your license to practice medicine or your permit to dispense or prescribe drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?  YES  NO
- c. been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct?  YES  NO
- d. been charged with or convicted of a felony or misdemeanor other than minor traffic violations?  YES  NO
- e. been evaluated, treated or hospitalized for any of the following:  YES  NO
  - alcohol
  - narcotics
  - central nervous systems stimulants or depressants
  - mental or emotional disorders
- f. had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? *If YES, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.*  YES  NO
- g. had Medicare/Medicaid fraud charges filed against you?  YES  NO
- h. Do you work with surgeons who have little, questionable or no malpractice insurance?  YES  NO

**If you answered Yes to any of the above questions, please provide full details in Remarks #38.**

- 25. Have you ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last fifteen (15) years, or are you presently involved in malpractice litigation?**  YES  NO

*If Yes, submit a separate form for each case in the last fifteen (15) years (See page 10).*

- 26. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?**
- a. A request for records from a patient and/or attorney related to an adverse outcome?  YES  NO
  - b. A letter from a patient and/or attorney regarding your medical treatment of a patient?  YES  NO
  - c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities?  YES  NO

- d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?
- i. Cardiac arrest  YES  NO
  - ii. Postoperative coma  YES  NO
  - iii. Postoperative neurologic deficits  YES  NO
  - iv. Unexpected death within 48 hrs. postoperatively  YES  NO
  - v. All others \_\_\_\_\_

27. Are you aware of a patient dissatisfaction with the outcome of a procedure, treatment or diagnosis?  YES  NO
28. Are you aware of any outstanding incidents, claims or suits (EVEN IF YOU BELIEVE THE OUTSTANDING CLAIM OR SUIT WOULD BE WITHOUT MERIT) that have not been reported to your current OR prior professional liability carrier? **If yes, please explain.**  YES  NO

**If you answered Yes to Questions 25-28, please provide full details in Remarks #38 and attach any additional documentation. An Incident/Claim Information Form must be completed for each incident, potential claim, claim or suit.**

**ANSWERS TO THE FOLLOWING QUESTIONS SHOULD REFLECT YOUR INTENDED PRACTICE AS OF THE DATE YOU WISH THIS POLICY TO BECOME EFFECTIVE.**

**29. Practice Situation**

a. Indicate all practice situations that apply to you:

- "Solo" Physician
- "Solo" Medical Corporation (please include name of corporation below)
- Stockholder of a Medical Corporation with more than one physician shareholder (please include name of corporation below)
- Medical Partnership (please include name of partnership below)
- Locum Tenens
- Independent Contractor
- Use of assumed name (DBA)
- Employed by another physician
- Employ another physician (If this employee is not insured by APAC, please submit current proof of coverage.)
- Other \_\_\_\_\_

If you checked any boxes above **other than** "Solo" Physician, list below the name of Applicable entity(ies) and/or any physician(s).

Name(s) of Entity(ies)	Name(s) of Physician Employer or Employee	Professional Liability Insurance Carrier	Employment/Contract Date (mm/dd/yy)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- b. Do you wish coverage for any of the above entities?  YES  NO
- If **Yes**, which one(s): \_\_\_\_\_

**Please submit a copy of the Corporate Charter.**

30. **Other Physicians:** Do you practice with other physicians not listed above?  YES  NO
- If **Yes**, list the physician(s) with whom you practice and describe the association.

Physician(s)	Association
_____	_____
_____	_____

**31. Experimental and Investigative Procedures**

Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy?  YES  NO

If **Yes**, indicate which of the following applies:

- Use of experimental drug, device or material under U.S. Food and Drug Administration or other governmental agency investigational protocol and licensure.
- Other experimental, investigative or unconventional drug or therapy.

PROCEDURES: \_\_\_\_\_  
\_\_\_\_\_

**32. Unusual Procedures**  N/A

List any unusual procedures that you perform within or outside of your specialty: \_\_\_\_\_  
\_\_\_\_\_

**33. Employees**

Do you employ any of the following healthcare professionals listed below?  YES  NO

\*If **Yes**, please include number of each and date employed.

	Number	Date Employed (mm/dd/yy)		Number	Date Employed (mm/dd/yy)
Nurse anesthetist	_____	_____	Physician's asst.	_____	_____
Nurse practitioner	_____	_____			

**\*In order for vicarious liability coverage or "shared limit" coverage to be provided to you:**

**These individuals must provide proof of individual coverage with this application or apply to APAC for coverage. Proof of insurance must show policy limits of at least \$250,000/\$750,000 and reflect the retroactive date.**

**34. CRNAs**

a) Do you employ or supervise any CRNA's?  YES  NO

If **Yes**, please complete the following: Number employed \_\_\_\_\_ Number supervised \_\_\_\_\_

b) Do CRNAs monitor or administer anesthesia to your private patients?  YES  NO

If **Yes**,

i) How many CRNAs do you supervise simultaneously?  YES  NO

ii) Do you administer anesthesia while you are supervising CRNAs?  YES  NO

c) Do you supervise CRNAs for which you do not receive a fee from a patient?  YES  NO

If **Yes**, do you have an indemnification agreement with the hospital or CRNA?  YES  NO

**Please attach a copy of the agreement.**

d) Do the CRNAs administer anesthesia while not under your personal direction?  YES  NO

If **Yes**, please describe: \_\_\_\_\_

**35. Practice Volume**

a) How many anesthetics do you perform or supervise in a year? \_\_\_\_\_

Do you obtain written informed consent for anesthetic procedures?  YES  NO

If **No**, please explain \_\_\_\_\_

36. Check monitors that you **routinely use** in the O.R. and P.A.C.U.:

**OR/PACU**

- Blood pressure cuff
- Electrocardiogram
- Pulse Oximeter

**OR/PACU**

- Mass Spectrometer
- Temperature
- End Tidal CO<sub>2</sub>

**OR/PACU**

- Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

37. Do you perform Chronic Pain Management Procedures?  YES  NO

If **Yes**, please answer the following questions: **(Please note: The policy form does not automatically include coverage for Pain Management. The underwriting committee must approve coverage for these procedures and the policy must be endorsed accordingly.**

Do you perform any of the following procedures?	<input type="checkbox"/> YES <input type="checkbox"/> NO	# of Annual Procedures
1. Cervical Epidural Injections?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
2. Thoracic Epidural Injections?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
3. Celiac Plexus Blocks?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
4. Insertion of spinal stimulator wires in the epidural space?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
a. Do you go higher than vertebral level T4?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
b. Is placement verified with fluoroscopy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
c. Have you been trained through a program of study that incorporated hands-on experience?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
d. Have you been credentialed by the hospital for these procedures?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
5. Insertion of epidural catheter for drug infusion? (Do not include post-op epidural for acute pain management)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
a. Do you go higher than vertebral level T4?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
b. Is placement verified with fluoroscopy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
c. Have you been trained through a program of study that incorporated hands-on experience?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
d. Have you been credentialed by the hospital for these procedures?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
6. Insertion of intrathecal catheter for drug infusion?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
a. Do you insert higher than vertebral level L2?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
b. Is placement verified with fluoroscopy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
c. Have you been trained through a program of study that incorporated hands-on experience?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
d. Have you been credentialed by the hospital for these procedures?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
If <b>No</b> , please explain: _____		
7. Neurolysis procedures?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
If <b>Yes</b> , please list nerves and techniques used: _____		
_____		
8. What new techniques do you now use which you did not use three years ago? _____		
_____		
9. Are you certified in Pain Management?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
a. By the ABA?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
b. By the American Board of Pain Medicine?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
c. Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Please specify _____		
10. What percentage of your practice is Chronic Pain Management?	_____ %	



**SUPPLEMENTAL WAIVER AND RELEASE**

I hereby acknowledge that the foregoing information constitutes my application for insurance with Anesthesiologists Professional Assurance Company (APAC). All statements are my own representations and are true, to the best of my knowledge. I have not knowingly withheld any information that is calculated to influence the judgment of APAC in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by APAC and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by APAC. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Recovery Network, individuals and APAC. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if I am insured by APAC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with APAC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of APAC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to APAC.

M.D./D.O.

\_\_\_\_\_  
Date

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

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or APAC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

**Fraud Statement  
Section 817.234(1)(b), Florida Statutes  
(if applicable)**

This section requires insurers to include a specified fraud statement on applications as well as claim forms. The requirement is effective March 1, 1996; however the Department has begun notifying companies in form filings that they must include it or refile it next year. The statute requires the statement to contain in substance the following language: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

**HOW DID YOU HEAR OF US?**

Please take a moment to check the appropriate box(es):

- Advertisement
- Agent
- Colleague
- Convention
- County Medical Society
- Direct Mail
- Former Insured
- Group Association
- Hospital Group
- Internet
- Professional Society
- Risk Management
- State Medical Association

**INCIDENT/CLAIM INFORMATION**

N/A  Initial \_\_\_\_\_

*All incidents/claims reported to current and prior carriers should be reported on this form.*

- 1. Name of patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_
- 3. Your relationship to patient: \_\_\_\_\_  
\_\_\_\_\_
- 4. Details of allegation(s): \_\_\_\_\_
- 5. Date of incident: \_\_\_\_\_ 6. Report date: \_\_\_\_\_
- 7. Insurance carrier: \_\_\_\_\_
- 8. Name of your defense attorney: \_\_\_\_\_
- 9. Other defendants: \_\_\_\_\_
- 10. Present status of claim (**check applicable answer and fill in amounts where needed**)
  - Precautionary/Incident report only Reserve Amount \$ \_\_\_\_\_
  - Suit threatened, no action taken Reserve Amount \$ \_\_\_\_\_
  - Notice of Intent filed Reserve Amount \$ \_\_\_\_\_
  - Suit pending Reserve Amount \$ \_\_\_\_\_
  - Dropped by claimant
  - Summary judgment in your favor
  - Court trial in your favor
  - Out of court settlement:  
Date Paid \_\_\_\_\_ mm/dd/yy Amount Paid \$ \_\_\_\_\_
  - Court settlement:  
Date Paid \_\_\_\_\_ mm/dd/yy Amount Paid \$ \_\_\_\_\_
- 11. Location of incident: \_\_\_\_\_
- 12. Condition and diagnosis at time of incident: \_\_\_\_\_  
\_\_\_\_\_
- 13. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_
- 14. Condition of patient subsequent to treatment (and DATES OF FOLLOW-UP TREATMENT) \_\_\_\_\_  
\_\_\_\_\_
- 15. Was the corporation sued:  YES  NO  
If Pending, Reserve Amount \$ \_\_\_\_\_  
Was payment made on its behalf?  YES  NO If Yes, amount paid \$ \_\_\_\_\_

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_