Podiatrist Application for Professional Liability Insurance — Claims-Made

Refer to www.lammico.com for a downloadable version of this application.

It is recommended that you submit your application at least 30 to 45 days in advance of your desired effective date in order to ensure a timely review of your application. Please read the following instructions in order to expedite the review of your application:

(1) Answer all questions or mark "N/A" where appropriate;
(2) Complete the attached Claim Addendum if a claim or suit has been filed against you.
(3) Submit a claim/loss history report from your previous carrier(s) - 10 years if applicable.
(4) Provide a copy of your current professional liability policy or declarations page.
(5) Sign and date your application on page 4.

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (3) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

When completed, please return this application to:

Louisiana Medical Mutual Insurance Company
One Galleria Blvd., Suite 700
Metairie LA 70001-7510
FAX: 504/841-5205 or 504/841-5300

If you have questions, please call the Underwriting Department at 504/831-3756 or 800/452-2120. Thank you for your interest in LAMMICO. We look forward to serving your professional liability insurance needs.

LAMMICO
Building Enduring Partnerships

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Podiatrist Professional Liability Application Claims-Made

Under the "claims-made" policy, coverage is limited to claims arising from the performance of professional services subsequent to the retroactive date stated in the declarations and first made against the company while the policy is in force.

Agency Name: (If using Agent)	Agency Address: (City, State, Zip)	Producer

General Information

Application # (LAMMICO use only) | | | | | | | | |

Name

Office Address (include city, state, zip) | Years at this location

Billing Address (include city, state, zip) | Other Locations (if any)

Home Address (include city, state, zip)

Employer ID (if any)	Social Security No.	Date of Birth	
Office Phone	Fax Number	Home Phone	E-mail Address
Desired Effective Date			

(LAMMICO use only)

Retroactive Date _____

Parish Code _____ Tax Code _____

Limits/Option _____

Discount Code _____ Discount _____ %

Group Code _____ Specialty/Class _____

Start of Practice Date _____

Professional Liability Limits Desired (Check one box)

Occurrence	Claims Made	Straight Through Coverage*
n/a	☐	$500,000 each medical incident/$500,000 aggregate
n/a	☐	$1,000,000 each medical incident/$1,000,000 aggregate
n/a	☐	$1,000,000 each medical incident/$3,000,000 aggregate
n/a	☐	$2,000,000 each medical incident/$2,000,000 aggregate
		Basic Limits Coverage
☐	☐	$100,000 each medical incident/$300,000 aggregate **with** PCF
☐	☐	$100,000 each medical incident/$300,000 aggregate **without** PCF

*Louisiana Patients' Compensation Fund participation is mandatory if you purchase limits greater than $100,000/$300,000

Underwriting and Rating Information

1.a. Please indicate which applies to you below:

☐ Solo Practitioner ☐ Partner in Partnership ☐ Shareholder in Professional Corporation

☐ Independent Contractor ☐ Preceptee ☐ Resident ☐ Employed (no ownership interest in employer)

1.b. If other than a solo practitioner, please complete any of the following which apply:

Names of partners or other members of the professional association or corporation: _____

Full corporation, partnership, or association name: _____

Name of employer (work 100% for employer without ownership interest): _____

Name, address, and telephone number of preceptor: _____

Name, address, and telephone number of residency program: _____

Name of residency director: _____

***NOTE**: If corporate or partnership coverage is desired, attach a copy of the Articles of Incorporation or the like.*

2. Please indicate the number of employees as follows: _____ Employed Podiatrists* _____ Podiatric Assistants

_____ Preceptees* _____ Residents*

***NOTE**: Employees noted with an asterisk must secure individual professional liability insurance for their own protection.*

3. Policy period of current professional liability coverage (mm/dd/yyyy): ____/____/_____ to ____/____/_____

4. Name of present professional liability insurance carrier: _____ How Long? _____

5. Type of policy you currently have: ☐ Claims-made ☐ Occurrence
If claims-made, what is the retroactive date on the policy? _____

6. Name of insurance carrier prior to present carrier (if applicable): _____

Claim Information

7. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
"Claim" means a demand received by the applicant for money or services, including the services of suit or litigation or arbitration proceeding against the applicant. If yes, please complete on CLAIM ADDENDUM at the end of this application for each allegation.

8. Are you aware of any incidents that have occurred that might reasonably lead to such a claim or suit? ☐ Yes ☐ No
If yes, please complete on CLAIM ADDENDUM at the end of this application for each incident.

Training/Professional Information

9. Podiatry college attended: _____ Year Graduated: _____

10. Post graduate training: _____

11. Did you serve a residency? ☐ Yes ☐ No How long? _____ Years Year completed: _____
Name of residency program: _____
Address: _____ Phone Number: _____
Residency director's name: _____

12. Did you serve a preceptorship? ☐ Yes ☐ No How long? _____ Years Year completed: _____
Name of preceptor: _____
Address: _____ Phone Number: _____

13. Are you board certified? ☐ Yes ☐ No By whom? _____ Certification Date: _____

14. Current podiatric license information. List all states in which you are licensed.

State and Parish/County	License Number	Practice time (hrs./week)

15. Are you an employee of a hospital? ☐ Yes ☐ No If yes, hospital name: _____

16. Are you an employee of a federal or state government? ☐ Yes ☐ No If yes, please specify: _____

17. Are you licensed to dispense narcotics? ☐ Yes ☐ No If yes, DEA number: _____

18. Do you advertise? ☐ Yes ☐ No If yes, please attach samples.

19. Do you treat patients participating in health maintenance organizations (HMOs)? ☐ Yes ☐ No If yes, percentage of your time with HMO patients: _____ %
What other responsibilities, if any, do you have with the HMO? _____

20. Do you treat patients participating in preferred provider organizations (PPOs)? ☐ Yes ☐ No If yes, percentage of your time with PPO patients: _____ %
What other responsibilities, if any, do you have with the PPO? _____

21. Has any state license of yours to practice podiatry been refused, revoked, suspended, or voluntarily surrendered? ☐ Yes ☐ No

22. Have you ever had a narcotics license revoked, suspended, or restricted? ☐ Yes ☐ No

23. Have you ever used any intoxicant, narcotic, or other psychoactive or depressant drug to the extent that it interfered with your ability to perform professional duties? ☐ Yes ☐ No

24. Have you ever had any professional liability insurance declined, canceled, or renewal refused for reasons other than the company's withdrawal from the podiatric professional liability market? ☐ Yes ☐ No

25. Have you ever had professional liability insurance issued on a restrictive basis (i.e., reduced limits, assigned a deductible, restricted coverage, surcharge rates)? ☐ Yes ☐ No

26. Have you ever been the subject of disciplinary proceedings or reprimanded by an administrative agency, a hospital, or a professional association? ☐ Yes ☐ No

27. Have you ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? ☐ Yes ☐ No

28. Have you ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

29. Have you ever had privileges at any hospital or other institution refused, revoked, suspended, or restricted? ☐ Yes ☐ No

30. Have you ever been disabled or had an interruption of your practice because of a disability? ☐ Yes ☐ No

On a separate sheet of paper, please provide a complete explanation of all YES answers to the questions listed above.

Current Practice/Procedure Information

31. Do you perform surgery in your office? ☐ Yes ☐ No

Do you perform surgery in a hospital? ☐ Yes ☐ No

Do you perform surgery in any other facility? ☐ Yes ☐ No

Name of hospital or other facility and type of surgical privileges: _____

32. Do you administer local anesthesia?
In the office: ☐ Yes ☐ No
In the hospital: ☐ Yes ☐ No

33. Do you perform surgery under general anesthesia?
In the office: ☐ Yes ☐ No
In the hospital: ☐ Yes ☐ No

34. Do you administer nitrous oxide analgesia?
In the office: ☐ Yes ☐ No
In the hospital: ☐ Yes ☐ No

35. Do you use a laser in your treatment of patients? ☐ Yes ☐ No

If yes, type of treatment: _____ How often do you use the laser? _____ times per week

Please indicate what type of training you received in the use of the laser (check all that apply below):

☐ Seminar ☐ Course ☐ Preceptorship ☐ Hands-on ☐ Other

Please specify program(s): _____

36. Please indicate if you perform any of the following (check all that apply below):

Osseous surgery on metatarsals	☐ Yes ☐ No	Use of prosthetics in the ankle joint?	☐ Yes ☐ No
Osseous surgery on tarsals	☐ Yes ☐ No	Office surgery on calcaneus or talus with exception of exostectomies and excision of supernumerary ossicles	☐ Yes ☐ No
Osseous surgery on digits	☐ Yes ☐ No		
Nail surgery	☐ Yes ☐ No	Incision and drainage of abscesses	☐ Yes ☐ No
Clubfoot procedure in office	☐ Yes ☐ No	Excision of verruca, molluscum contagiosum, cysts, and other benign lesions	☐ Yes ☐ No
Flatfoot procedure in office	☐ Yes ☐ No		
Canvus foot procedure in office	☐ Yes ☐ No	Metatarsus adductus (not to include primus adductus) procedure in office	☐ Yes ☐ No
Tenotomies	☐ Yes ☐ No		
Post-operative care	☐ Yes ☐ No	Laser surgery resulting in cutting or insulting bone	☐ Yes ☐ No
Ankle arthroplasty	☐ Yes ☐ No	Paratendon stripping of Achilles tendon	☐ Yes ☐ No

37. Have you attended a malpractice risk management program in the last year? ☐ Yes ☐ No

If yes, please specify program(s) (include dates and locations): _____

38. How many continuing education credits have you received in the last year? _____

Warranty Information

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I understand that the statements and answers will be relied upon by Louisiana Medical Mutual Insurance Company (LAMMICO) and are material in determining whether insurance coverage will be issued or renewed.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to renew a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

Applicant Signature

Date

Certificates Of Insurance

List hospitals where you hold or are applying for staff privileges. Place an X in the box in front of each hospital requiring a certificate of insurance. Also list other entities (i.e., credentialing organizations, managed care entities, etc.) requiring certificates of insurance.

		Institution Code (LAMMICO use only)
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CLAIM/SUIT/COMPLAINT INFORMATION ADDENDUM

IF ADDITIONAL SPACE IS REQUIRED PLEASE PHOTOCOPY THIS FORM AS NEEDED. PLEASE TYPE OR PRINT IN BLACK INK.
NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

Patient's name _____ Age_____ Sex_____

Relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon):_____

Allegation as stated by patient/plaintiff: _____

_____

_____

Location of incident _____ City_____ State _____
(Hospital, Office, etc.)

Date of incident_____ Insurance Carrier _____
Month/Day/Year

Other defendants: _____

Present status: Open ☐ Closed ☐ Date Closed _____ Amount paid: $ _____ Settlement ☐ Judgment ☐

Condition and diagnosis at time of incident: _____

_____

_____

_____

_____

Dates and description of treatment rendered: _____

_____

_____

_____

_____

Condition of patient subsequent to treatment and dates of follow-up treatment:_____

_____

_____

_____

_____

Defense counsel: _____

Plaintiff's counsel: _____

I hereby declare the above information is complete and true to the best of my knowledge and belief.

_____ _____
Applicant Signature in full Date

_____
Name (please print or type):