LSU MEDICAL STUDENT

Application for Excess Professional Liability Insurance

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

In order to allow adequate time for review of your application, we ask that you please submit your application at least 30 days in advance of your requested effective date.

Please read the following instructions in order to expedite the review of your application:

1. Please refer to the Frequently Asked Questions page for answers to common questions
2. Answer all questions or mark “N/A” where appropriate
3. Submit all information as requested by the application if a claim or suit has been filed against you
4. **Submit payment**
    - **$180 for $1M/$3M total limits (LAMMICO requires a separate check for each rotation)**
    - **Application and payment must be received together**
5. Sign and date your application

If you have questions, please contact a Policyholder Support Representative at 504.831.3756 or 800.452.2120.

Thank you for your interest in LAMMICO. We look forward to serving your medical professional liability insurance needs.

When completed, please remit this application to:

LAMMICO
One Galleria Blvd., Suite 700
Metairie, LA 70001
FAX: 504.841.5205

LAMMICO

Frequently Asked Questions

1. **How do I submit my application?**
   Applications will be accepted via mail or personal delivery to the LAMMICO Metairie office located at 1 Galleria Blvd., Suite 700, Metairie, LA 70001

   NOTE: Application must be received with check(s) to process

2. **How much does professional liability coverage cost?**
   Total Limits - $1 million / $3 million coverage = $180

3. **How do you accept payment for the application?**
   Checks will be accepted via mail or personal delivery to the LAMMICO Metairie office located at 1 Galleria Blvd., Suite 700, Metairie, LA 70001

   Please make checks payable to LAMMICO. ***LAMMICO does not accept cash or money orders.***

   NOTE: Check(s) must be included with the application to process

4. **I do not know when the rotation will take place, what should I put for the dates of rotation?**
   We require the dates of the rotation to be on the application. The dates of the rotation can be changed after submission of the application, but before the rotation takes place.

5. **I am applying to multiple locations. Can I put all of them on one application?**
   Yes, however, LAMMICO requires a separate $180 check for each rotation.

6. **After I apply and decide not to accept or I am declined for the rotation, do I get a refund?**
   LAMMICO will shred the original check should a rotation be declined or not accepted. To qualify for a return of your payment (or a refund), you will need to notify us via email prior to the requested effective date that the rotation has been declined or not accepted.

7. **Do you deposit the check(s) as soon as I submit the application?**
   No, LAMMICO will hold the check and then deposit the check two weeks before the start date of the rotation.

Edition: January 2025

LAMMICO

L.S.U. Medical Student Application for Excess Professional Liability Insurance

Under the "**Occurrence**" policy, coverage is provided for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is made.

Personal Information

Full Name (Last, First, Middle)	Suffix ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV	Gender ☐ M ☐ F

Email Address	Social Security Number	Date of Birth (mm/dd/yyyy)	Expected Graduation Date

Primary Mailing Address (include city, state, zip)

Home Address (include city, state, zip)	Home/Cell Phone

Rotation School(s)

Rotation Date(s)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Underwriting and Rating Information

Total Limits Provided: $1 million / $3 million

LAMMICO coverage is $500,000 per incident / $1.5 million annual aggregate excess over primary LSUHSC $500,000 limit

NOTE: If you answer yes to any of the following questions, please provide details.

1. Have you been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No
2. Have you now or have you ever had a chronic illness or physical limitation that impairs or could tend to impair your ability to practice medicine? ☐ Yes ☐ No
3. Have you been charged with or convicted of a crime (other than a minor traffic violation)? ☐ Yes ☐ No
4. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority? ☐ Yes ☐ No
5. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
   If *yes*, has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No
6. Are you aware of any circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No
   If *yes*, has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No

Sign and date application in the space below.

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 LAMMICO and are material in determining not only whether insurance coverage will be issued or renewed, but also correct classification.

I hereby authorize the release of my name, address, policy, and premium information by LAMMICO to its agents or designees subject to confidentiality and nondisclosure agreements.

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 issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

Applicant Signature: _____ **Date:** _____

FRAUD NOTICE – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application of insurance is guilty of a crime and may be subject to fines and confinement in prison.