



**Florida Doctors Insurance Company**  
**Application for Physicians and Surgeons**

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: \_\_\_\_\_ Male Female

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

5. List all medical license numbers:

a. _____	c. _____
State Lic. # Status	State Lic. # Status
b. _____	d. _____
State Lic. # Status	State Lic. # Status

Number Street City State Zip % of Practice time at this location

Telephone # Fax # E-Mail Address

7. List additional practice locations including all offices, nursing homes, urgent care clinics and other non-hospital locations. Please identify additional location (i.e., additional private practice office, nursing home, clinic, etc.)

Type of Practice \_\_\_\_\_

Number Street City State Zip % of Practice time at this location

Telephone # Fax # E-Mail Address Website

Do you treat patients that were admitted to nursing homes by other physicians? YES NO

**8. Scope of Coverage:**

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

Practice Name Address Start Date (mm/dd/yy) - End Date (mm/dd/yy)

Practice Name Address Start Date (mm/dd/yy) - End Date (mm/dd/yy)

Please use "Remarks" section if additional space is needed. Provide evidence of separate coverage.

9. Home Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
 Number Street Telephone

City State Zip ( ) Fax

10. Mailing Address (choose one): Home Primary Address Other (please specify in Remarks Section)

**11. Please indicate:**

a. Your average weekly patient load \_\_\_\_\_ b. Your total weekly practice hours \_\_\_\_\_

c. Approximate monthly practice time if semi-retired or practicing part-time \_\_\_\_\_ N/A.

If part-time, when did you first reduce your practice hours? \_\_\_\_/\_\_\_\_/\_\_\_\_

Have the number of reduced hours shown above changed since this date? YES (please explain) NO

Do you expect to continue the reduced practice for at least the next year? YES NO (please explain)

Are you involved in another part time-practice for which you already have coverage? YES (provide proof of coverage) NO

**Please include part-time practice details and provide coverage information, if applicable, in the "Remarks" section.**

**12. a.** List all hospitals where you currently *have* or *have applied* for staff privileges (include courtesy staff privileges) and percentage of your hospital practice. **Policy information, including cancellation, will be released to these facilities.**

Hospital	City/State	% of Practice
_____	_____	_____
_____	_____	_____
_____	_____	_____

b.If you do not or will not have admitting privileges, please explain why and describe in detail your procedure for handling patients who may require immediate in-patient care . \_\_\_\_\_

**13. Specialty:**

a. Medical specialty currently practiced \_\_\_\_\_ Sub-Specialty \_\_\_\_\_

b. Specialty for which you want coverage \_\_\_\_\_

**14. Medical Education:**

Medical School \_\_\_\_\_ City/State/Country \_\_\_\_\_ Graduation Date \_\_\_\_\_

**15. Postgraduate Medical Training:**

a. Internship \_\_\_\_\_  
Hospital \_\_\_\_\_ City/State/Country \_\_\_\_\_ From: Mo./Yr. To: Mo./Yr.

b. Residency \_\_\_\_\_ Completed?  
Hospital \_\_\_\_\_ City/State/Country \_\_\_\_\_ From: Mo./Yr. To: Mo./Yr. YES NO

Specialty: \_\_\_\_\_

c. Explain any additional years spent in a residency program \_\_\_\_\_

d. Explain any gaps in time from date of medical school graduation to completion of residency: \_\_\_\_\_

e. Fellowship: \_\_\_\_\_  
Hospital \_\_\_\_\_ City/State/Country \_\_\_\_\_ From: Mo./Yr. To: Mo./Yr.

Type of Fellowship \_\_\_\_\_ Completed YES NO

**PLEASE INCLUDE A COPY OF YOUR CURRENT CV**

**16. Board Certification:**

**STATUS**

Name of Board	Cert.	Elig.	Date Certified	*Date Eligibility Expires
_____			_____	_____
_____			_____	_____

\*If eligible for over five years but not certified, please explain:

How many times have you taken the Board exam for certification? Oral \_\_\_\_\_ Written \_\_\_\_\_

**17. Changes in Practice**

a. Have you practiced continuously for the past ten (10) years? YES NO  
If **No**, please explain in "Remarks" section

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. Are you a member of the Florida Birth-Related Neurological Injury Compensation Association (NICA)? YES NO  
If **Yes**, please include a copy of your current coverage certificate.

**19. Prior Insurance**

Insurance history for the previous ten (10) years - please include loss report(s) from prior carrier(s) or National Practitioner Data Bank (NPDB) report:

Coverage Period

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

**20. 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" section.

**21. 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

**22. 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)? YES NO

(Please attach a copy of your current Declarations page.)

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.**

**23. 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, non-renew 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	central nervous system stimulants or depressants
mental or emotional disorders	narcotics

- 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? YES NO

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.

- g. had Medicare/Medicaid fraud charges filed against you YES NO

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

- 24.** Are you currently involved in malpractice litigation? YES NO

- 25.** Have you **ever** been involved in a malpractice claim or suit, including any expression of an intent (i.e. closed records requests, incident reports and Notices of Intent, even if suit was never filed)? YES NO  
If **Yes**, submit a separate Incident Claim Information form for each case.

**26.** Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that **any** of the following circumstances 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 or communication from a patient, patient's representative, friend, relative 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

27. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?

- a. Cardiac arrest YES NO
- b. Postoperative coma YES NO
- c. Postoperative neurological deficits YES NO
- d. Unexpected death within 48 hrs. postoperatively YES NO
- e. All others YES NO

28. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? YES NO

29. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are 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? YES NO  
**If yes, please explain.**

If you answered Yes to Questions 24-29, please provide full details in "Remarks" section 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.**

**30. Practice Situation (Please include a copy of your Business Letterhead)**

a. Indicate all practice situations that apply to you:

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

If you checked any of the above boxes **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 include a copy of the Corporate Charter.**

c. If you checked Independent Contractor or Employed by another physician, provide a copy of the contract.

**31. 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

**32. Non-Hospital Births**

Do you provide direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital? YES NO

If Yes, give full details: \_\_\_\_\_  
 \_\_\_\_\_

**33. Terminations of Pregnancy**

Do you perform terminations of pregnancy? YES NO

If Yes, please provide the following information:

Location	Name	# Performed Monthly at Each Location	Maximum Gestational Age at Each Location
Office	_____	_____	_____
Hospital	_____	_____	_____
Other	_____	_____	_____

**34. Non-Hospital Procedures**

a. Do you perform procedures in a non-hospital setting where other than local anesthesia is administered? YES NO

If Yes, type(s) used: \_\_\_\_\_

i) Location                      Surgicenter                      Office                      Other Non-Hospital Facility

ii) Who administers the anesthesia?

b. For surgicenter or other non-hospital facility, please provide the name and address of such. \_\_\_\_\_  
 \_\_\_\_\_

c. List the surgical procedures you perform in your office or other non-hospital facility:

Procedure	# Weekly	Where Performed	Do you have privileges at an accredited hospital for this procedure?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

d. Do you maintain a full emergency cart? YES NO

i) Do you follow a protocol for checking the cart on a regular basis? YES NO

ii) Are the checks documented? YES NO

**35. Weight Control**

a. Does your practice involve weight reduction or control, other than prescribing exercise? YES NO  
 (Percentage of patients exclusively for weight reduction or control \_\_\_\_\_%.)

If **Yes**, please explain fully including name of medication(s) prescribed or dispensed, or surgery performed: \_\_\_\_\_

b. Do you solicit or advertise for weight control patients? YES NO

If **Yes**, submit copies of all advertisements.

**36. 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: \_\_\_\_\_

**37. Please indicate with an "X" below which of the following procedures, techniques or practices you perform or intend to perform.**

- |  |  |  |
|--|--|--|
| Assisting in Major Surgery<br>Baker's Chemical Peels<br>Blepharoplasty<br>Cardiac Catherization (left Heart)# done annually _____<br>Chelation therapy (other than for the treatment of heavy metal poisoning)<br>D & C (diagnostic only)<br>Deliveries (# done in past 5 years _____)<br>Experimental Surgery | Hair Transplants<br>Hydrogen Peroxide Therapy<br>Pain Management (if yes, explain in "Remarks")<br>Prenatal Care<br>Radiation Oncology<br>Scalp Reductions<br>Sclerotherapy (deep vein)<br>Shock Therapy<br>Spine Surgery<br>Polymethylmethacrylate injections (bone cement) | Suction Lipectomy - type and areas of use ( <i>submit proof of training if outside of residency</i> ):<br>Telemedicine (if yes, explain in "Remarks")<br>Ultraviolet Light Therapy (other than UVB or PUVA)<br>Vasectomies<br><b>I do not perform any of these Procedures.</b> |
|--|--|--|

**38. Unusual Procedures**      N/A

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

**39. Employees**

Do you employ any of the following healthcare professionals listed below? YES NO  
 \*If **Yes**, please include number of each and date employed – (*see note on page 8 regarding coverage conditions*).

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

**\*In order for vicarious/defense coverage to be provided to you:**

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

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

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

Do the CRNA's give anesthesia while not under your personal directions? YES NO

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

**40. Obstetrics and Gynecology** N/A

1. Do you limit your practice to gynecology only? YES NO

If **Yes**, is your practice strictly office based? YES NO

2. Do you render prenatal care exclusive of delivery? YES NO

3. How many deliveries do you perform annually? \_\_\_\_\_

**41. Pain Management/Physical Medicine and Rehabilitation** N/A

**Do you perform any of the following procedures?**

# of Annual Procedures

1. Cervical Epidural Injections? YES NO \_\_\_\_\_

2. Thoracic Epidural Injections? YES NO \_\_\_\_\_

3. Celiac Plexus Blocks? YES NO \_\_\_\_\_

4. Epidural-Caudal, Translumbar or Selective Injections? YES NO \_\_\_\_\_

5. Facet-Cervical or Lumbar Injections? YES NO \_\_\_\_\_

6. Sacroiliac Joint and Gleno-humeral Joint Injections? YES NO \_\_\_\_\_

7. Hip Joint Injections? YES NO \_\_\_\_\_

If **Yes**, explain \_\_\_\_\_

8. Assisted Spinal Endoscopy (Percutaneous Laser Discectomy)? YES NO \_\_\_\_\_

9. Insertion of spinal stimulator wires in the epidural space? YES NO \_\_\_\_\_

a. Do you go higher than vertebral level T4? YES NO \_\_\_\_\_

10. Insertion of epidural catheter for drug infusion? YES NO \_\_\_\_\_

(Do not include post-op epidural for acute pain management)

a. Do you go higher than vertebral level T4? YES NO \_\_\_\_\_

11. Insertion of intrathecal catheter for drug infusion? YES NO \_\_\_\_\_

a. Do you insert higher than vertebral level L2? YES NO \_\_\_\_\_

12. For the procedures listed in #9, 10 and 11, please complete the following:

a. Is placement verified with fluoroscopy? YES NO

b. Have you been trained through a program of study that incorporated hands-on experience? YES NO

c. Have you been credentialed by the hospital for these procedures? YES NO

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

13. Are you certified in Pain Management? YES NO

a. By the American Board of Pain Medicine? YES NO

b. Other YES NO

Please specify \_\_\_\_\_

14. What percentage of your practice is Chronic Pain Management? \_\_\_\_\_%

15. What new techniques do you now use which you did not use three years ago? \_\_\_\_\_





**SUPPLEMENTAL WAIVER AND RELEASE**

I hereby acknowledge that the foregoing information constitutes my application for insurance with Florida Doctors Insurance Company (FLDIC). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences or circumstances related to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of FLDIC 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 FLDIC 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 FLDIC. 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 Resource Network, individuals and FLDIC. 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 FLDIC, 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 FLDIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FLDIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FLDIC.

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Signature of Applicant MD/DO

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 FLDIC 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)**

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.

**Insurance coverage is subject to underwriting review and approval and premium payment No coverage exists until an initial premium deposit is received and a Binder or Coverage Summary Page, together with any applicable endorsements, has been issued by FLDIC to the policyholder.**

FLORIDA DOCTORS INSURANCE COMPANY  
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Jacksonville, Florida 32256  
FAX: 904-296-1013  
Phone: 800-FLA-DOCS  
[www.FLDIC.com](http://www.FLDIC.com)

**FLORIDA DOCTORS INSURANCE COMPANY  
INCIDENT/CLAIM INFORMATION**

*All incidents/claims reported to current and prior carriers should be reported on this form (including incidents/claims which occurred during residency).*

1. Name of patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_

3. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): \_\_\_\_\_  
\_\_\_\_\_

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 \$ \_\_\_\_\_

Out of court settlement:

Date Paid \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_  
mm/dd/yy

Suit threatened, no action taken

Reserve Amount \$ \_\_\_\_\_

Dropped by claimant

Summary judgment in your favor

Court trial in your favor

Court settlement:

Date Paid \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_  
mm/dd/yy

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: \_\_\_\_\_

**NOTICE**  
**Florida Doctors Insurance Company**  
**Experience Rating Program**

FLDIC has established the following guidelines for the application of Loss Free Discounts and Surcharges for Losses. Any interruption of insurance or going without insurance (going bare) will require that the experience period start over as of the date insurance was continuously maintained. The number of Loss Free years is calculated from January 1<sup>st</sup> of the year practice began.

<b>Loss Free Years</b>	<b>Discount</b>
0 – 4	None
5 – 9	10%
10 – 14	20%
15 or more	25%

<b>Number of Claims*</b>	<b>Surcharge</b>
2	50%
3	200%
4	500%

“Loss” means:

Class 0-2 (All Other Counties in the State)

Any indemnity payment over \$25,000 or any indemnity reserve of \$100,000 or greater.

Class 0-2 (Dade, Broward and Palm Beach territories)

Any indemnity payment over \$50,000 or any indemnity reserve of \$100,000 or greater.

Class 3-8 (all territories)

Any indemnity payment over \$50,000 or any indemnity reserve of \$100,000 or greater.

\* Provided the physician remains eligible for standard coverage from an underwriting standpoint, each and every claim shall have a determination of whether it is chargeable. The surcharge once assessed shall apply for a three-year period commencing on the next renewal date. An additional claim under an already surcharged policy will result in a new surcharge period beginning. FLDIC reserves the right to decline an applicant in lieu of utilizing this surcharge program.

For further information please contact your FLDIC Representative or contact the FLDIC Underwriting Department at the number shown in the documents to which this notice is attached.