Print Form

Agent

Gulf Atlantic Legal Defense Insurance, Inc.

2549 Barrington Circle Tallahassee, FL 32308
Tel: 850.385.8555 Fax: 850.385.1657

APPLICATION FOR LEGAL DEFENSE EXPENSE INSURANCE

All answers should reflect your anticipated practice for the next 12 months.

This is an application for a **Legal Defense Expense Insurance Policy.** Coverage under this policy only reimburses **You** for certain attorneys' fees and other expenses as defined in the policy (**"Defense Costs"**) which arise as a result of a medical malpractice **Claim** made against **You**. ***This policy does not cover You for settlements, judgments, awards or any other form of damages ("Damages") for which You may become obligated as a result of a medical malpractice Claim.*** The policy also does not cover legal expenses or attorneys' fees incurred by any injured person, or for **Defense Costs** incurred by or on behalf of any person other than **You** in defense of a claim.

In order for **You** to be covered under this policy for **Defense Costs** arising out of a **Claim** against **You**, the **Claim** must arise from **Medical Incidents** or events which occurred after the policy's retroactive date and which are first made against **You** and reported to the company while this policy is in force.

Coverage is subject to underwriting approval and payment of the initial premium. No coverage exists until the initial premium has been received and a Declarations Page, together with any endorsements that may apply, have been issued to the named insured or their Agent.

Please complete the following in ink and answer all questions in full. If a question does not apply, state "none" or "N/A." You may attach pages if you need additional space to completely respond to a question. Please include a copy of your **letterhead** and all your advertisements, along with a copy of your **curriculum vitae** with this application.

GENERAL INFORMATION

Name			
Address			
City	County	State	Zip
FL Medical License No.	Social Security No.		
Date of Birth:	Home Phone No.		
Office Phone No.	Fax No.	E-mail Address:	

POLICY INFORMATION

Date you desire coverage to begin: (month/date/year)

Do you desire Prior Acts coverage? ☐ No ☐ Yes Prior Acts Date Requested: (month/date/year)

If yes, Prior Acts form MUST be completed. **(Note: If no retroactive date is requested, we will quote with NO PRIOR ACTS COVERAGE.)**

Limits of Liability Requested: ☐ $100,000 / 200,000

PRACTICE INFORMATION

Does the address provided above represent the only location / facility at which you provide professional services? ☐ Yes ☐ No
If **NO**, please provide the name, address and phone / fax numbers for each on a separate piece of paper.

Your Practice Specialty

Subspecialty

Type of Practice ☐ Private ☐ Hospital ☐ Group ☐ Clinic ☐ Other:

Indicate procedures for which you are the (P) PRIMARY physician or for which you (A) ASSIST. Leave blank any procedures which you do not perform.

Procedure	P	A	Procedure	P	A	Procedure	P	A
Admin. Of General Anesthesia	☐	☐	Fractures–Ty pe _____	☐	☐	Pain Management–Rx Oxycontin	☐	☐
Angiography	☐	☐	Impotency Therapies	☐	☐	Pregnancy Terminations	☐	☐
Angioplasty	☐	☐	Insertion of IUDs	☐	☐	Pre/Postnatal Treatment	☐	☐
Assist in Surgery	☐	☐	Invasive Radiology	☐	☐	Radiation Therapy	☐	☐
Chelation Therapy	☐	☐	Kidney Biopsy	☐	☐	Sex Change Surgery	☐	☐
Chemical Facial Peels	☐	☐	Laser Surgery/Type _____	☐	☐	Sigmoidoscopy-(How Many cms____)	☐	☐
Colonoscopy	☐	☐	Liposuction	☐	☐	Spinal Taps	☐	☐
D&C's	☐	☐	Liver Biopsy	☐	☐	Surgical Treatment for Obesity	☐	☐

Procedure	P	A	Procedure	P	A	Procedure	P	A
Elective cosmetic surgery/Type _____	☐	☐	Neonatology	☐	☐	Vasectomies	☐	☐
			Neurologic Surgery	☐	☐	X-Rays (In Office)	☐	☐
			Obstetrics (# deliveries _____)	☐	☐	Weight Loss Control using Drugs	☐	☐
Chelation Therapy	☐	☐	Ophthalmology	☐	☐			
Electroshock Therapy	☐	☐	Orthopedic Surgery	☐	☐			
Emergency Room _____ Hrs/Wk	☐	☐						

1. ☐ Yes ☐ No — Do you perform any other invasive procedures or surgeries not listed above? If **YES**, list each, number performed annually and where performed. (Use extra paper if necessary)

2. ☐ Yes ☐ No — Are you Board Certified? If **YES**, Name of Board:
   If **NO**, are you Board Eligible? ☐ Yes ☐ No
   If **YES**, how many times have you tested? Written_____ Oral_____

3. ☐ Yes ☐ No — Do you participate in the practice of telemedicine?

4. ☐ Yes ☐ No — Do you have staff membership/privileges at a hospital? If **YES**, provide name, address and type of privileges; If **NO**, explain why and what arrangements you have made to admit patients. (List hospitals - use extra paper if needed.)

INSURANCE INFORMATION

IMPORTANT NOTE TO APPLICANTS HAVING A PRIOR CLAIMS-MADE INSURANCE POLICY

Unless you are purchasing an extended reporting period or "Tail" Coverage on your expiring insurance policy, you will not be covered under that expiring policy for Claims which first arise after that policy's termination date. ***The Gulf Atlantic policy for which You are now applying does not provide coverage for Damages. It is a legal expense only policy.*** If You are leaving a claims-made insurance policy which provides indemnity coverage for Damages, we strongly urge You to review the reporting requirements of Your expiring policy and to report any Medical Incidents which reasonably could result in a Claim (to the extent permitted by that policy) before it terminates.

5. ☐ Yes ☐ No — Are you currently covered for medical professional liability coverage? If **YES**, please attach a copy of your current Declarations page. If **NO**, when did your coverage expire? Please provide name of last carrier and expiration date.

6. ☐ Yes ☐ No — Has your professional liability insurance application/coverage ever been canceled, non-renewed or issued on special terms? If **YES**, please explain.

7. ☐ Yes ☐ No — Have you ever been treated for, or have you ever had any problem with, drug or alcohol use? (This includes any charges of DUI, whether or not you were convicted.) If **YES**, please describe, including any and all treatments, hospitalizations and the current status.

8. ☐ Yes ☐ No — Have you ever been treated for, or have you ever had, any emotional or behavioral problem or illness? If **YES**, please describe, including all treatments, hospitalizations and the current status.

9. ☐ Yes ☐ No — Have you ever been charged with a crime other than a minor traffic violation? If **YES**, please explain.

10. ☐ Yes ☐ No — Has your license to practice, authority to prescribe drugs, or hospital privileges ever been restricted, suspended, revoked, acted upon, or non-renewed in any state? If **YES**, please explain.

11. ☐ Yes ☐ No — Do you treat patients participating in an:
    ☐ HMO ☐ PPO ☐ Other Managed Care Program (Please describe.)
    A. What percentage of your practice time is spent with these patients? _____ %
    B. What other responsibilities do you have with the managed care program? _____
    C. Are you an employee under an "at Risk Contract?" ☐ Yes ☐ No
    If **YES**, what percentage of this is your practice? _____ %
    Are physician referrals, fees and hospital expenses included in your fees? ☐ Yes ☐ No

PARTNERSHIP/CORPORATION/PROFESSIONAL ASSOCIATION INFORMATION

12. Do you practice as part of or with a:

☐ Sole Proprietorship ☐ Professional Association ☐ Solo P.A.

☐ Corporation ☐ Limited Liability Partnership ☐ Other (describe)

If the answer to any of the above is YES, provide the legal name of the entity or practice:

NAME: _____

Would you like to cover Claims arising out of your vicarious liability for your Professional Association and/or those entities?
Yes ☐ No ☐ (There is no charge for this endorsement.)

Name(s): _____

13. ☐ Yes ☐ No Are you an owner of the entity described? If **YES**, describe your ownership interest.

14. ☐ Yes ☐ No Are you ☐ employed by ☐ under contract to the entity described? If **NO**, describe your relationship with the entity.

15. ☐ Yes ☐ No Do you share office space with any physician not employed by or contracted to the entity? If **YES**, please describe.

16. ☐ Yes ☐ No Do you, or does the entity described, employ, contract with or supervise any physician, other than you, any CRNA, PA-C, ARNP or other medical professionals of this nature?

☐ Yes ☐ No If so, would you like to cover yourself for Claims arising out of your vicarious liability for those persons? (If **YES**, please provide us with the names, specialties and curriculum vitae of each of these persons. **Proof of their insurance is also necessary for us to underwrite this coverage.** There is no additional charge for this coverage.)

EDUCATION

17. This portion of the application must be completed in full **OR** a current **Curriculum Vitae** must accompany this application.

Medical School: Date Degree Obtained:

Name:

City/State/County:

Internship Type Dates:

Name

City/State

Residency Type Dates:

Name

City/State

Fellowship Type Dates:

Name

City/State

Other Training Type Dates:

Name

City/State

Are you a graduate of a non-US Medical school? ☐ Yes ☐ No School Name:

If you are a graduate of a non-US medical school, are you certified by the Educational Council for Foreign Medical School Graduates?

☐ Yes ☐ No If **NO**, please explain:

CLAIMS INFORMATION

As used in this Application, "Claim" means notice to you of an actual, threatened, or possible demand for money or services arising out of your professional services. A claim includes any medical incident or other situation which you believe may result in a demand being made against you, including, but not limited to, a patient complaint, poor or unexpected results, an attorney's request for medical records or a lawsuit; "Medical Incident" means any act, error or omission in providing or failure to provide professional services by you. This includes your responsibility for anyone acting under your direction or control.

19. ☐ Yes ☐ No — Do you have any open Claims or Medical Incidents?
If YES, please describe in detail all Claims, Medical Incidents or other items, their status, and whether they have been reported to and are covered by your current or prior insurance carriers. You may either complete the attached claim form or provide us with a written statement concerning the claim with this requested information.

19. ☐ Yes ☐ No — Do you have any closed Claims or Medical Incidents?
If YES, please describe in detail all Claims, Medical Incidents or other items, their status, and whether they have been reported to and are covered by your current or prior insurance carriers. You may either complete the attached claim form or provide us with a written statement concerning the claim with this requested information.

20. ☐ Yes ☐ No — Are you aware of any open or closed Claims or Medical Incidents involving someone under your direction or control?
If YES, please describe in detail all Claims, Medical Incidents or other items, their status, and whether they have been reported to and are covered by your current or prior insurance carriers. You may either complete the attached claim form or provide us with a written statement concerning the claim with this requested information.

POLICY PREMIUM

21. ☐ Yes ☐ No — Are you paying the policy premium? If NO, who is paying the premium on your behalf?

22. ☐ Yes ☐ No — If you are not paying the premium on this policy, does the person/entity paying the premium have the right to make policy decisions and to receive notices and return premium on your behalf? If YES, you must sign an "Appointment of Representative" form. Please contact us and we will send you this form.

SUPPLEMENTAL WAIVER / RELEASE

Any person who knowingly and with intent to injure, defraud or deceive any insurer files any statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I hereby certify that the above statements, representations and responses are true, complete and correct, and I understand and agree that you will rely on such statements, representations and responses in making a decision as to whether to issue a policy to me. If the answers contained in the application or this certification materially change during any policy period, I agree to immediately notify you. If transmitted to Gulf Atlantic by facsimile, I agree that the facsimile copy of this application received by Gulf Atlantic shall be, and shall have the same effect for all purposes, as the original. I hereby authorize any person or organization, including attorneys who now or in the past have represented me, to release to Gulf Atlantic any and all information, whether privileged or not, relating to my employment, education, training, hospital privileges (whether granted or not), my malpractice insurance (including but not limited to the underwriting and claims files of any present or former malpractice carrier insuring me), and any and all information which Gulf Atlantic may reasonably request to assist it in underwriting my application for insurance or in administering any claim made against me under my Gulf Atlantic policy.

By signing below, I hereby acknowledge on behalf of myself and all applicants:

1. That Gulf Atlantic Legal Defense Insurance, Inc. is a legal expense insurance company under Chapter 642, Florida Statutes, and that the policy I am applying for is a legal expense policy ONLY.
2. That the policy I am applying for does not provide indemnity coverage for damages arising from medical malpractice claims, and only provides reimbursement for those legal expenses outlined in the policy.
3. That the policy I am applying for does not meet the physician financial responsibility requirements as outlined in Section 458.320, Florida Statutes, and that I (or we) must separately comply with the provisions of that Section.

PLEASE ATTACH ALL REQUESTED ITEMS TO THIS APPLICATION.

Agent Signature	Applicant Signature
Agent License No.	Date:

Please include a copy of your letterhead and curriculum vitae with this application.

Click to Print Form
Sign and Fax to 800-357-0652