INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY
INDIVIDUAL PROFESSIONAL LIABILITY APPLICATION

IRMIA RISK MANAGER
5814 Reed Road
Fort Wayne IN 46835-3568
Phone: 1-800-836-5727 Fax: 260-486-0782

Submitted by: ______________________(Agency)

General Information – All questions must be completed ("see attached" is unacceptable unless additional space is required). If additional space is required, it must be in the same format as the application. Please do not alter the application.

1. Name: ______________ ______________ ______________ ______________
First Middle Last Professional Designation

2. Practice Address: ______________ ______________ ______________ ______________
Street (must include physical address) City State Zip

3. Practice County: ______________

4. Additional Locations: ☐ YES ☐ NO
NOTE: *If YES, list each separate address, including county, on attachment*

5. Preferred Mailing Address: ☐ Same as above (If different, must be an **Indiana** address.)

______________ ______________ ______________ ______________
Street (must include physical address) City State Zip

6. Date of Birth: ______/______/______

Policy Information (Occurrence Policy)

7. Requested Effective Date: ______/______/______
Note: *All effective dates are subject to underwriting approval. If you are joining an existing insured group, your coverage may be issued to a common expiration date*

8. Latest Insurer: ______________ Policy#: ______________ Expiration Date (mm/dd/yy): ______________

License, Training & Current Practice Information

9. Indiana License Number: ______________ Other State License Number(s): ______________ ______________ ______________

10. Hospitals where you currently hold privileges:

Hospital	City/County	Type of Privileges	% of Practice

INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY

11. What is your medical or surgical specialty? ______________________________

    Do you have a sub-specialty? ☐ YES ☐ NO If YES: ______________________________

12. What are the maximum number of hours devoted to your Indiana practice in any given week (including patient contact, administrative, and on-call time)?

    _________ Hours per week

13. For the purpose of this policy, are you acting under a fellowship? ☐ YES ☐ NO

    If YES, list specialty of fellowship______________________________

14. What are the maximum number of hours devoted to your fellowship practice in any given week (including patient contact, administrative, and on-call time)?

    _________Hours per week

15. In the last ten (10) years,

    (a) Have you discontinued major surgical procedures? (*Explain on separate sheet*) ☐ Yes ☐ No

    (b) Has anything changed in your practice? (*Explain on separate sheet*) ☐ Yes ☐ No

16. Are you ***American Board Certified***? ☐ Yes ☐ No Name of Board:______________________________

17. Do you work in an emergency room? ☐ Yes ☐ No

    If yes, is it: ☐ your primary responsibility? **OR** ☐ for hospital privileges only ?

18. List Medical School training locations:

	College/ Hospital	State/Country	Date Completed
Medical School			(mm/dd/yy)
Residency			
Medical School			
Residency			

19. Are you a stockholder in a professional corporation or member of a partnership/association? ☐ YES ☐ NO If yes, please list below.

    ____

20. Will you be performing activities that will be covered by another professional liability policy? ☐ YES ☐ NO

    If Yes, complete the following:

    Practice name location(s)______________________________

    ____

    Names of Carrier(s)______________________________

Note: If coverage is desired for the entities listed in 19, you must complete a separate Corporate/Partnership Liability Application.

21. As an individual, do you (*not your corporation*) **employ or contract** any healthcare providers (MDs, Dentist, Hygienists, Nurses, X-ray techs, Medical lab techs, Physical Therapists, Medical Assistants, etc)? ☐ YES ☐ NO

If yes, please complete the following Employee Information section in full. All sections must be complete. If the answer is No, None or N/A, please indicate this on the application. ***If physicians are not insured by IRMIA, please provide certificate of insurance showing ISO code reported to the Indiana Patient's Compensation Fund.***

Employee Information

Name and Professional Designation		Indiana License #	Specialty	Sub-Specialty
Surgery None Minor Major ☐ ☐ ☐	OB Yes No ☐ ☐	Radiation Therapy Yes No ☐ ☐	Current Insurer & Expiration Date	Participates in the Indiana Patient's Compensation Fund* ☐ Yes ☐ No
Name and Professional Designation		Indiana License #	Specialty	Sub-Specialty
Surgery None Minor Major ☐ ☐ ☐	OB Yes No ☐ ☐	Radiation Therapy Yes No ☐ ☐	Current Insurer & Expiration Date	Participates in the Indiana Patient's Compensation Fund* ☐ Yes ☐ No
Name and Professional Designation		Indiana License #	Specialty	Sub-Specialty
Surgery None Minor Major ☐ ☐ ☐	OB Yes No ☐ ☐	Radiation Therapy Yes No ☐ ☐	Current Insurer & Expiration Date	Participates in the Indiana Patient's Compensation Fund* ☐ Yes ☐ No
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Name and Professional Designation		Indiana License #	Specialty	Sub-Specialty
Surgery None Minor Major ☐ ☐ ☐	OB Yes No ☐ ☐	Radiation Therapy Yes No ☐ ☐	Current Insurer & Expiration Date	Participates in the Indiana Patient's Compensation Fund* ☐ Yes ☐ No

***Note:**

- If shareholders/partners, employees and contractors in the following list ***are eligible*** to qualify as healthcare providers for the Indiana Patient's Compensation Fund on an individual basis per Article 18 34-18-2-14 (1), they ***are required*** to participate. Please provide proof of such participation for each employee unless they have an IRMIA policy. This list includes physicians, dentists, nurse anesthetists, nurse practitioners, nurse midwives, optometrists, podiatrists, and psychologists.
- **This participation must be in force for the length of the policy being requested.**

22. **Physicians or surgeons, please complete pages 4 and 5 selecting from the following any procedures you perform. For all other types of healthcare providers, complete the appropriate section on page 6.**

Physician and Surgeon

☐ Assist in surgery on your own patients

☐ Assist in Surgery on other than your own patients
☐ Abortions

☐ Acupuncture ☐ General Anesthetic
☐ Therapeutic/Local Anesthetic

☐ Anesthesia/General/Spinal/ Caudal
☐ Pulse Oximetry
☐ End Tital CO_2

☐ Angiography

☐ Angioplasty

☐ Appendectomies ☐ incidental only

☐ Arteriography

☐ Arthroscopy

☐ Biopsy (Endoscopic)

☐ Blepharopigmentation

☐ Blepharoplasty – Brow Lifts
Cosmetic _____ % of total practice
Reconstruction _____ % of total practice

☐ Botox Injections

☐ Breast Implants
Cosmetic _____ % of total practice
Reconstruction _____ % of total practice

☐ Breast Reduction

☐ Bronchoscopy

☐ Broncho-Esophagology

☐ Catheterization/Arterial/Cardiac/Diagnostic
☐ Swan-Ganz
☐ Right Heart (other than CVP Lines)
☐ Left Heart

☐ Carpal Tunnel Surgery

☐ Cataract Surgery

☐ Chelation Therapy

☐ Chemical Peels ☐ Superficial ☐ Medium ☐ Deep

☐ Cholecystectomy

☐ Cleft Lip/Palate Surgery

☐ Colonoscopy

☐ Cosmetic Plastic Surgery ☐ Buttock implants
☐ Calf implants ☐ Cheek/Chin/Lip implants
☐ Face Lifts ☐ Face Lifts Mini (done with laser)

☐ Cryosurgery (Cervical)

☐ Cryosurgery (other than external lesions)

☐ D & C's

☐ Diagnostic Embolization

☐ Discograms

☐ Electromagnetic Therapy

☐ Embolization

☐ ERCP Upper GI Endoscopy

☐ Esophageal Dilation/pneumatic/mechanical not bougie or olive

☐ Gastrointestinal Endoscopy

☐ Gynecological Surgery

☐ Hair Transplants
☐ Follicular Unit Transplantation
☐ Other

☐ Hemorrhoidectomies

☐ Herniorrhaphy

☐ High Velocity/Low Amplitude (HVLA) on the cervical spine on patients 18 years of age or older

☐ High Velocity/Low Amplitude (HVLA) on the cervical spine on patients younger than 18 years of age

☐ Hysterectomies

☐ Kyphoplasty

☐ Laparoscopy

☐ Laser Surgery

☐ Laser Therapy Endoscopic

☐ Laser Therapy Non-Endoscopic

☐ Liposuction ☐ Tumescent Technique Only ☐ Other

☐ Lithotripsy

- ☐ Needle Biopsy
  - ☐ Lung
  - ☐ Prostate
  - ☐ Other: ____________________
- ☐ Lymphangiography
- ☐ Mammograms
- ☐ Myelography
- ☐ Nerve Blocks
  - ☐ Lumbar Epidural Steroid
  - ☐ Paraspinal
  - ☐ Sciatic
  - ☐ Facet
  - ☐ Paravertebral
  - ☐ Peripheral
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Triggerpoint Injection
  - ☐ Intrathecal Pumps
  - ☐ Spinal Cord Stimulators
- ☐ Normal Obstetrical Deliveries
  - ______ How many per year
- ☐ Cesarean Sections
  - ______ How many per year
- Prenatal Practice
  - ☐ See patients during the 1st and 2nd Trimester
  - ☐ See patients to term but do not perform delivery
  - ☐ See patients to term and perform delivery
- ☐ Open reduction of fractures
- ______ % Osteopathic Manipulation on patients 18 years or older
- ______ % Osteopathic Manipulation on patients younger than 18 years of age
- ☐ Oxidation Therapy
- ☐ Pacemakers
  - ☐ Permanent ☐ Epicardial ☐ Endocardial
  - ☐ Temporary
- ☐ Peritoneoscopy
- ☐ Phlebography
- ☐ Pnuemoencephalography
- ☐ Polypectomy
- ☐ Prolotherapy
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye Injections
- ☐ Rectal Ozone Therapy
- ☐ Rhinoplasty
- ☐ Shock Therapy
- Sigmoidoscopy
  - ☐ 60cm or less
  - ☐ Greater than 60cm
- ☐ Silicone Injections
- ☐ Skin Flaps/Grafts ☐ Cosmetic ☐ Reconstruction
- ☐ Tonsillectomy & Adenoidectomy's
- ☐ Thigh Lift
- ☐ Tubal Ligations
- ☐ Vasectomies
  - ☐ Own Patients Only
  - ☐ Own & Other Than Own Patients
- ☐ Vertebroplasty
- ☐ Weight Control Therapy/Surgery
  - ☐ Medication – Weight Control
  - ☐ Bariatric Surgery Laparoscopic
  - ☐ Bariatric Surgery Non-Laparoscopic
  - ☐ Other____________________

List other procedures (do not restate your specialty): ____________________

____

____

☐ **I do <u>NOT</u> perform any invasive procedures.**

Do you as a physician engage in research or teaching at a Nationally Accredited College of Medicine? ☐ Yes ☐ No

If yes, indicate percentage of practice ________%.

Dentists

Specify Practice

☐ General Dentistry ☐ Oral Surgery ☐ Dental Anesthesiology ☐ Oral Pathology ☐ Other ______________________

Select from the following any techniques or procedures you perform (CPT/CDT codes where applicable):

☐ None

☐ Unconscious Sedation

☐ Intravenous/Intramuscular Conscious Sedation

☐ Third Molar Extractions – Fully Impacted (D7240, D7241, D7250)

☐ Third Molar Extractions – Partially Impacted (D7210, D7220, D7230)

☐ Third Molar Extractions – Erupted (D71110, D7120)

☐ Radiation Therapy

Nurses

Select from the following:

☐ Licensed Practical Nurse

☐ Registered Nurse

☐ Advanced Registered Nurse Practitioner

☐ Certified Registered Nurse Anesthetist

☐ Nurse Midwife

Do you perform Radiation Therapy? ☐ Yes ☐ No

Other

Chiropractor ☐ Optometrist ☐ Occupational Therapist ☐ Paramedic or EMT ☐

Physical Therapist ☐ Physician or Surgeon Assistant ☐ Podiatrist ☐ Psychologist ☐

Respiratory Therapist ☐ Other ☐ ______________________________

Probations, Suspensions & Revocations

23. Within the past ten (10) years:
    a. Have you had your license **revoked** in any state? ☐ YES ☐ NO
    b. Have you had your license **suspended** in any state? ☐ YES ☐ NO
    c. Have you had your license **invoked (placed on probation)** in any state? ☐ YES ☐ NO
    d. Has any hospital **revoked** your staff privileges? ☐ YES ☐ NO
    e. Has any hospital **suspended or restricted** your staff privileges? ☐ YES ☐ NO
    f. Have you been impaired by alcoholism, abuse of or addiction to a controlled substance? ☐ YES ☐ NO
    g. Have you been impaired by a mental or physical disability (e.g., convulsive disorders, mental illness, multiple sclerosis, arthritis etc.) with the exception of blindness? ☐ YES ☐ NO

24. Have you ever voluntarily surrendered your state license or hospital privileges? ☐ YES ☐ NO
25. Have you ever been convicted of a crime? ☐ YES ☐ NO

Note: *If yes, attach documents related to the above actions.*

Claims Information

26. Within the past ten (10) years:
    Have any claims or suits for alleged malpractice been brought against you? ☐ YES ☐ NO

Note: *If yes, you must complete the following Claims Information in full and* ***attach current prior carrier loss runs (other than IRMIA).*** *If reserve amounts for open claims are* ***not*** *known, please state unknown.*

Provide the following information for each claim or suit brought against you within the past TEN years.

Date of Incident mm/dd/yy	Plaintiff Name	Status of Suit or Claim		Amount of Indemnity Loss or Reserve
		Open	Closed	

INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY

Assignment of right to cancel coverage

By signing below, I assign to the following employer or named third party both the right to cancel and to receive any unearned premium.

Name:____

Address: ____________________ ____________ ______ ______

Street City State Zip

However I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to IRMIA. ***Please note*** your right to cancel and receive any premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

____

Signature of Applicant

IMPORTANT: Please Read Carefully and Sign

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree this application shall be the basis of the contract with the Indiana Residual Malpractice Insurance Authority (IRMIA). I agree to notify IRMIA if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm or professional association.

By completing this application for professional liability insurance, I affirm that I am licensed to provide professional services in my specialty in the state of Indiana and have made a diligent effort to obtain coverage as required by Indiana Code (IC) 34-18-17-6 and have been declined by two or more insurers as evidenced by the attached declination letters. I do hereby apply for coverage with IRMIA and warrant the above statements and answers. I also authorize the release of claim and suit information from any prior insurer.

The Medical Protective Company is the appointed "Risk Manager" for IRMIA and is providing the application solely under those auspices. As a result, the application for insurance is provided solely for the purpose of evaluating the applicant's qualifications for coverage under IRMIA and should not be seen as an offer of insurance from The Medical Protective Company. Pursuant to I.C. 34-18-17-3, The Medical Protective Company's separate, personal, and independent assets are not liable for or subject to use or expenditures for the purpose of providing insurance by IRMIA.

If the "Risk Manager" declines to accept your application, you will be notified of the decision in writing, including the reasons for the declination. If this occurs, you will have 10 days from the date of the notice to file an appeal with the Commissioner of Insurance who will review the decision of the "Risk Manager" and enter an appropriate order.

Signature of Applicant	Professional Designation	Date of Signature
Printed Name of Applicant		Telephone Number
		Fax Number

IMPORTANT: This application must be signed by both the applicant and the producer

Signature of Producer	Indiana P & C License Number	Date of Signature
Name of Agency/Independent Agent	Telephone Number	
Agency IRS Number	Fax Number	
	E-Mail Address	

Agency Mailing Address	City	State	Zip