CAPITAL INSURANCE SERVICES

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Individual Medical Malpractice Quote Sheet

Name: ______________________ Degree: ________ SSN #: ______________

Phone: ______________________ E-Mail: ______________________

Home Address: ______________________ City: __________ State: _____ Zip: __________

Please list all practice locations: *(If additional practice locations are needed please attach a separate sheet)*

Street Address: ______________________ City: __________ State: _____ Zip: __________

Practice Name: ______________________ Days: __________ % of Practice: __________

Street Address: ______________________ City: __________ State: _____ Zip: __________

Practice Name: ______________________ Days: __________ % of Practice: __________

Do you practice under a dba (doing business as) or LLC (Limited Liability Company? ☐ Yes ☐ No

If yes, please list all names: ____

____

Do you serve as a Medical Director? ☐ Yes ☐ No

If yes, please list the name of the facility(ies): ______________________________

Education, Training and Certification

Please attach a copy of your Curriculum Vitae (CV).

Coverages

Limits Requested			
	$100,000 each claim / $300,000 aggregate		$300,000 each claim / $900,000 aggregate
	$200,000 each claim / $600,000 aggregate		$500,000 each claim / $1,000,000 aggregate
	$250,000 each claim / $750,000 aggregate		$1,000,000 each claim / $3,000,000 aggregate

1. Requested Effective Date: ______________ Retro Date *(if claims-made)*: ______________
2. What is your specialty: ______________________ % of Practice: __________
3. What is your sub-specialty: ______________________ % of Practice: __________
4. How many hours do you practice on average per week: __________
5. Desired type of coverage: ☐ Claims-Made ☐ Occurrence
6. Are you requesting Prior Acts Coverage? ☐ Yes ☐ No Requested Retro Date: ______________
7. Deductible Amount: __________ ☐ Indemnity Only ☐ Indemnity & Expense ☐ None
8. Do you need Excess Coverage Limits? ☐ Yes ☐ No Requested Amount: ______________
9. Were your prior limits: ☐ Shared ☐ Separate
10. Did you purchase / receive a reporting endorsement *(tail coverage)*? ☐ Yes ☐ No
11. Do you practice any of the following? ☐ Ayurvedic Medicine ☐ Chinese Medicine (including Acupuncture) ☐ Holistic Medicine ☐ Homeopathic Medicine ☐ Naturopathic Medicine
12. Will you be carrying additional professional liability insurance with another company? ☐ Yes ☐ No

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Information on Paramedical Employees*

1. Is any person licensed, certified, or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician in any of the following areas: ☐ Yes ☐ No

Anesthesiologist Assistant	Emergency Medical Technician (EMT)	Physician's Assistant (PA)
Certified Nurse Anesthetist (CRNA)	Nurse Midwife	Psychologist
Certified Nurse Practitioner (CNP)	Optometrist	Surgeon's Assistant (SA)
Cytotechnologist	Perfusionist	

*Any paramedical desiring coverage must submit a paramedical application. A separate charge may apply.

Personal History

Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily suspended, or otherwise investigated or limited in any way? ☐ Yes ☐ No

If yes, provide a brief explanation and submit any supporting documents necessary. ____________________

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Loss Information

Have you ever been involved in a malpractice claim or suit? ☐ Yes ☐ No
(If yes, provide a narrative and disposition)

Do you have knowledge of any pending claims or situations which may give rise to claims? ☐ Yes ☐ No
If yes, have you notified your current insurer? ☐ Yes ☐ No

(If no, you must notify present insurer of all pending claims/incidents)

Has any company refused, declined, cancelled, or imposed special conditions/limitations on your professional liability coverage? ☐ Yes ☐ No If yes, please explain: ____________________

____

____

Current Insurance Information

Company Name: ____________________ Annual Premium: ____________________

Prior Limits: ____________________ Expiration Date: ____________________

Premium Classification: *Please complete page 3*

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Premium Classification – Please check any of the following that apply to you practice:

- ☐ Elective Abortions
  - ☐ Prescribe Preven, or related derivatives
  - ☐ Prescribe Mifepristone, or related derivatives in combination with cytotec?
- ☐ Acupuncture
- ☐ Anesthesia
  - ☐ Spinal
  - ☐ Caudal
  - ☐ General
  - ☐ Local
  - ☐ Other ____________
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On patients of others
  - ☐ On own patients
- ☐ Bariatric Surgery
- ☐ Blepharoplasty
- ☐ Breast Biopsy
- ☐ Breast Implants
  - ☐ Cosmetic
    ________% of practice
  - ☐ Reconstructive
    ________% of practice
- ☐ Bronchoscopy
- ☐ Cardiac – major surgery
- ☐ Cardiovascular Disease – major surgery
- ☐ Chelation therapy (for other than heavy metal poisoning)
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Cholecystectomy, Laparoscopic
- ☐ Circumcision (other than newborns)
- ☐ Colon and Rectal – major surgery
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Cryosurgery (other than external lesions)
- ☐ Dermatological Surgery
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen Injections
  - ☐ Cryosurgery (superficial only)
  - ☐ Dermabrasion
  - ☐ Eye Liner Pigmentation
  - ☐ Fat Transfer
  - ☐ Hair Transplants
  - ☐ Laser Hair Removal
  - ☐ Laser Skin Resurfacing
  - ☐ Microdermabrasion
  - ☐ Silicone Injections
  - ☐ Tumescent Liposuction
  - ☐ Other ____________
- ☐ D&C
- ☐ Dermatopathology
- ☐ Echocardiography
- ☐ Electrocardiography
- ☐ Emergency Medicine
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy
- ☐ ERCP / EGD / ERC
- ☐ Exchange Transfusions in Newborns
  How many per year? ____________
- ☐ Fertility Treatment
- ☐ Fluoroscopy
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Gastroscopy
- ☐ General – major surgery
- ☐ Gynecology – major surgery
- ☐ Hand – major surgery
- ☐ Head and Neck – major surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia Repair
- ☐ Hip Nailings
- ☐ Hyperbaric Medicine
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Intensive care for newborns within a Tertiary Care Unit
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ Laryngology – major surgery
- ☐ Laser Surgery
- ☐ Left Heart Catheterization
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Lumbar Fusion
- ☐ Mammography
- ☐ Myelography
- ☐ Myomectomy
- ☐ Neonatology
- ☐ Neurology – major surgery
- ☐ Norplant Insertion/Extraction
- ☐ Obstetrics/Gynecology – major surgery
  - ☐ Normal Deliveries
  - ☐ C-Sections
  - ☐ VBAC
    By Induction? ☐ Y ☐ N
    Induction agent: ____________
- ☐ Ophthalmology – major surgery
- ☐ Organ Transplant
- ☐ Orthopedic – major surgery
  - ☐ Spines
  - ☐ No Spines
- ☐ Osteopathic Manipulative Medicine
- ☐ Otology – major surgery
- ☐ Otorhinolaryngology – major surgery
  - ☐ Including elective cosmetic procedures
  - ☐ Not including elective cosmetic procedures
- ☐ Pain Management
  - ☐ Medication Only
  - ☐ Facet Blocks
  - ☐ Selective Nerve Root Blocks
  - ☐ Rhizotomy
  - ☐ Spinal Injections
  - ☐ Dorsal Root Gangliotomies
  - ☐ Thoracic Sympathectomies
  - ☐ Spinal Cord Stimulators
  - ☐ Implantation/Removal of Drug Infused Pumps
  - ☐ Sphenopalatine Lesioning
  - ☐ Trigeminal Lesioning
  - ☐ Cordotomies
  - ☐ Other ____________
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Percutaneous Vertebroplasty
- ☐ Permanent Pacemaker
- ☐ Plastic – major surgery
- ☐ Polypectomy
- ☐ Prenatal Care
- ☐ Prolotherapy
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye
- ☐ Rhinology – major surgery
- ☐ Roux-en-y
- ☐ Sclerotherapy
- ☐ Scoliosis Surgery
- ☐ Shock Therapy
- ☐ Sterilization Procedures
- ☐ Thoracic Surgery ____________%
- ☐ Thyroidectomy
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Transgender Surgery and/or Hormonal Gender Conversion
- ☐ Trigger Point Injections
- ☐ Tubal Ligation
- ☐ Urology – major surgery
- ☐ Vascular Surgery ____________%
- ☐ Vasectomy
- ☐ Weight Control ____________%
  - ☐ Bariatric Bypass
  - ☐ Gastric Bubble
  - ☐ Gastric Stapling
  - ☐ Other
  - ☐ Medications Prescribed (please list)
    ____
    ____
    ____
- ☐ **None of the above apply to my practice.** ____________
  (Please Initial)
- ☐ **Other Procedures (List):**
  ____
  ____
  ____
  ____

If you are applying for coverage for an obstetrical practice, do you have privileges to perform C-sections at each hospital you staff? ☐ Yes ☐ No
Important: If "no", please provide full details of your back-up arrangements on a separate sheet.

If applicant is approved for coverage it will be his/her responsibility to notify the Company of any changes in practice specialty, including but not limited to practice location, procedures, affiliation, etc. Failure to notify the Company of such changes could require retroactive upward premium adjustment and in the event of a claim could lead to a denial of coverage.