



Agency:
Address:

Phone/email:

APPLICATION FOR HPIX MEMBERSHIP AND INSURANCE

Name (First, Middle Initial, Last)

MD DO

Business Address (Include City, State, Zip)

Business Phone	Mobile Phone::	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Business Fax::	E-mail Address:	Date of Birth:
Home Phone:	Contact Name::	Social Security No:

SECONDARY ADDRESS: Home Other

Street Address

City, State, Zip

PROFESSIONAL EDUCATION

Medical School Name	City	State	Country	Year Completed
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Residency (list all resident training locations)

1.	Hospital Name	State	Country	From (MM/DD/YY)	To (MM/DD/YY)	Specialty Completed
2.	Hospital Name	State	Country	From (MM/DD/YY)	To (MM/DD/YY)	Specialty Completed
3.	Hospital Name	State	Country	From (MM/DD/YY)	To (MM/DD/YY)	Specialty Completed

Fellowship

Hospital Name	State	Country	From (MM/DD/YY)	To (MM/DD/YY)	Specialty Completed
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Date you entered private practice for the first time: _____

LICENSURE

States in which you hold a license to practice medicine. Indicate what percentage of your total practice is spent in each. For surgeons and obstetricians, base your percentages on surgeries or deliveries.

State	License Number	Date of License	% of Total Practice

1. Has your medical license in any state ever been suspended, revoked or restricted? Yes No
2. Are you currently under investigation by any state licensing board or agency? Yes No
3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited? Yes No
4. Have you ever suffered from or been treated for any substance abuse, disability, mental illness or serious physical injury or illness that has or might affect your ability to practice medicine or surgery? Yes No
If yes, state the illness or disability and the date it occurred below.
5. Have you ever been arrested for, charged with or convicted of a crime other than a minor traffic violation? Yes No
If yes, provide details below.
6. Do you treat inmates? Yes No
If yes, provide the number of hours per week: _____
7. Do you teach, supervise or proctor medical students, residents or fellows? Yes No
If yes, provide the number of hours per week: _____
8. Do you participate in clinical trials for any pharmaceutical or for any organization acting on behalf of a pharmaceutical? Yes No
If yes, describe below.
9. Do you own, operate or serve as an executive, administrative officer, medical director or department head for any hospital, nursing home, non-hospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization? Yes No
If yes, indicate its name and describe your duties below.
10. Do you hold any positions outside of your principal medical or surgical practice (e.g., working in a hospital emergency room or part time at a clinic or nursing home, working for an HMO or other managed care or insurance company, serving as a Medical Director, etc.)? Yes No
If yes, indicate for whom you provide these services below.
11. Has any hospital ever taken action to deny, suspend, revoke or restrict your medical staff privileges on your application or reapplication for medical staff privileges? Yes No
If yes, explain below and provide pertinent documentation.
12. Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? Yes No
If yes, explain below and provide pertinent documentation.
13. Do you provide services over the internet? Yes No

**Question
Number**

Fully explain any yes answers and provide supporting documentation

COVERAGE HISTORY

SUBMIT A COPY OF YOUR MOST RECENT POLICY DECLARATIONS

List your previous professional liability insurers for the last **10 years**, begin with most recent insurer.

Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date

1. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement (Tail coverage)? If yes, provide proof of coverage. Yes No
2. Has your application for professional liability insurance ever been declined, or has your policy premium ever been surcharged, canceled or nonrenewed by the insurer?
If yes, explain below. Yes No
3. Has your professional liability coverage always been continuously in force? Yes No
4. Will you be performing activities which will be covered by another professional liability policy?
If yes, indicate who will provide this coverage and what professional services it will cover. Yes No

**Question
Number**

Fully explain any yes answers and provide supporting documentation

CLAIMS HISTORY

- 1. In the past ten years, has any malpractice claim or suit been made against you? Yes No
If yes, how many? _____
- 2. Do you have knowledge of any incident, adverse outcome or other circumstances that might reasonably lead to such a claim or suit? Yes No
If yes, how many? _____ Have all of them been reported to your previous insurers? Yes No

Complete a Claims Supplement Form for each claim, suit or potential claim.

ATTACH LOSS RUN FROM ALL INSURERS LISTED UNDER THE COVERAGE HISTORY SECTION

COVERAGE SELECTION

Desired coverage effective date: _____ 12:01 a.m.

Desired coverage type:

- CLAIMS-MADE **With Prior Acts Coverage.** Retroactive date used by your existing carrier: _____ 12:01 a.m.
- CLAIMS-MADE Complete prior acts application.
- CLAIMS-MADE-PLUS **Without Prior Acts Coverage** (decline or do not need retroactive coverage). The retroactive date on the policy applied for will be the same as the effective date of coverage.
- Includes extended reporting endorsement (tail coverage).**

Optional Waiver of Consent to Settle 5% discount to premium. If you choose this option, your coverage will be changed. An endorsement will be attached to your policy giving the company the sole right to settle any claim as it deems appropriate. Would you like this optional coverage applied to your policy? Yes No

PRACTICE INFORMATION

- 1. What is your medical specialty? _____
- 2. What is your medical subspecialty ? _____
- 3. Are you board certified? Yes No Specialty _____ Date Certified _____
If no, are you board eligible? Yes No Specialty _____ Date Certified _____
- 4. Have you ever failed a Board Exam? Yes No
- 5. Have you changed medical specialties within the past five years? If yes, complete below Yes No

Specialty	Insurance Carrier	Hours per Week	From	To
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PLEASE PROVIDE CURRICULUM VITAE

Describe the practice for which you need insurance:	PRACTICE HOURS PER WEEK	
	Average hours (not just patient contact)	
	Patient visits (in office, hospital, etc.)	
	Surgeries (major in hospital)	
	Obstetrical deliveries	

Locations where you practice. List principal location first. Total percentage of practice at all locations should equal 100%.

PRACTICE LOCATIONS

1.	Address	City	State	Zip Code	% of Practice
2.	Address	City	State	Zip Code	% of Practice
3.	Address	City	State	Zip Code	% of Practice

HOSPITAL LOCATIONS

1.	Hospital Name	City	State	County	Privilege Type	% of Practice
2.	Hospital Name	City	State	County	Privilege Type	% of Practice
3.	Hospital Name	City	State	County	Privilege Type	% of Practice

Locations (other than present) where you have practiced since completion of formal training (include military or public service organizations):

Practice Name and Location	From	To

PRACTICE ORGANIZATION

Check the boxes that best describe your practice affiliation(s):

Employment Status

- Employee
- Shareholder/Partner***
- Solo Unincorporated***
- Solo Corporation***
- Independent Contractor for

Entity Type

- Professional Corporation
- Business Corporation
- Limited Liability Corporation
- Partnership
- Professional Association
- Joint Venture
- Other

***Entity application must be completed.**

Corporation, Partnership or Employer Name: _____

MEDICAL PROCEDURES

1. Check any of the following procedures applicable to your practice for which you require HPIX coverage:

- Abortions
 - Acupuncture
 - Therapeutic
 - General Anesthetic
 - Anesthesia
 - General
 - Spinal
 - Conscious Sedation
 - Caudal
 - Angioplasty
 - Appendectomy
 - Arthroscopy
 - Assist in Major Surgery
 - Own patients only
 - Other than own patients
 - Bariatric Surgery
 - Bypass
 - Gastric Bubble or Jejunio-Ileal bypass
 - Gastric Stapling
 - Gastric Banding
 - Other _____
 - Biopsy by Aspiration
 - Other Biopsy
Location _____
 - Blepharoplasty
 - Cosmetic _____ % of practice
 - Reconstruction _____ % of practice
 - Bone Fractures (closed treatment)
 - Botox Injections
 - Clinical Setting
 - Non-Clinical Setting
 - Breast Biopsy
 - Breast Implants
 - Cosmetic _____ % of practice
 - Reconstruction _____ % of practice
 - Bronchoscopy
 - Cardiac – major surgery
 - Cardiovascular disease- major surgery
 - Cataract Surgery
 - Catheterization
 - Swan-Ganz
 - Right Heart (other than CVP lines)
 - Left Heart
 - Chelation Therapy
 - Chemonucleolysis
 - Cholecystectomy
 - Cholecystectomy, Laparoscopic
 - Circumcision (other than newborns)
 - Colon & Rectal – major surgery
 - Colonoscopy
 - Colposcopy
 - Critical Care Specialist
 - Cryosurgery (other than external lesions)
 - D&C
 - Dermatological surgery
 - Chemical peels
 - Eye Liner pigmentation
 - Fat Transfer
 - Hair Transplants
 - Laser Hair Removal
 - Laser Skin Resurfacing
 - Microdermabrasion
 - Silicone Injections
 - Tumescent Liposuction
 - Other _____
 - 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 & Neck-major surgery
 - Hemorrhoidectomy
 - Hernia repair
 - Hip nailings
 - Hospitalist
 - Hyperbaric Medicine
 - Hysterectomy
 - Hysteroscopy
 - Intensivist
 - Intensive care for newborns within a Tertiary care unit
 - Interventional Radiology
 - Angiography
 - Arteriography
 - Phlebography
 - Other _____
 - In-Vitro Fertilization
 - Laminectomy
 - Laparoscopy
_____ Diagnostic _____ Cholecystectomy
 - Laryngology-major surgery
 - Myomectomy
 - Laser Surgery
 - Lasik
 - Liposuction
 - Lithotripsy
 - Mammography
 - Myelography
 - Neonatology
 - Nerve Blocks
 - Facet
 - Triggerpoint Injection
 - Neurology-major surgery
 - Norplant Insertion/Extraction
 - Obstetrics/Gynecology-major surgery
 - C-Sections – How many annually? _____
 - Normal Obstetrical Deliveries
How many Annually? _____
 - VBAC – How many annually? _____
 - Ophthalmology-major surgery
 - Organ Transplant
 - Orthopedic-major surgery
 - Spines No Spines
 - Osteopathic manipulative medicine
 - Otology – major surgery
 - Otorhinolaryngology – major surgery
 - 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 Surgeries
 - Percutaneous vertebroplasty
 - Permanent Pacemaker
 - Plastic-major surgery
 - Polypectomy
 - Prenatal Care (other than first trimester)
 - During second trimester
 - To term but do not deliver
 - To term and deliver
 - Prolotherapy
 - Radiation or X-Ray Therapy
 - Radiopaque Dye Injection
 - Rhinology-major surgery
 - Shock Therapy
 - Sigmoidoscopy
 - Less than 50 cm
 - Greater than 50 cm
 - Skin Flaps/Grafts
 - Cosmetic
 - Telemedicine
 - Thoracic Surgery _____ %
 - Thyroidectomy
 - Tubal Ligation
 - Urgent Care Medicine
 - Vasectomy
 - Weight Control Medication
 - Other Medical Techniques
- List Procedures _____

- Chemabrasion
- Collagen Injections
- Cryosurgery (superficial only)
- Dermabrasion
- Lumbar
- Myofascial
- Occipital
- Paravertebral

2. Do you perform any procedure not typical to the specialty in which you received your residency or fellowship training? Yes No

If yes, describe those activities. _____

CERTIFICATION AUTHORIZATION AND SIGNATURE

CONDITIONS OF MEMBERSHIP

There are several conditions to the undersigned's membership and continued membership with HPIX. Failure to comply with any of these conditions is grounds for non-renewal of the undersigned's membership and insurance policy. These conditions include, but are not limited to, that the undersigned hereby agrees to:

- (1) Accept and cooperate with coordinated defense to the extent ethically permissible.
- (2) Participate in and cooperate with programs that promote intensive risk management whenever requested by HPIX or its attorney-in-fact. Whenever requested by HPIX or its attorney-in-fact, the undersigned hereby agrees to undergo, at the undersigned's expense, and cooperate with a practice audit by an independent third party selected by HPIX or its attorney-in-fact to review various administrative and clinical patterns of practice.
- (3) Report incidents at the time they become known to the undersigned.

The undersigned agrees to fully comply with HPIX's conditions of membership, including those listed above, and agrees that the undersigned's membership in HPIX and insurance policy may be non-renewed by HPIX if the undersigned fails to comply.

The undersigned certifies that the information in this application is true and correct and authorizes the release and exchange of any information regarding the undersigned's medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which the undersigned is or has been a member and HPIX.

The undersigned further agrees to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

NOTICE TO NEW JERSEY APPLICANTS:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's signature: _____ Date: _____