



## HEALTHCARE PROVIDERS INSURANCE EXCHANGE

### APPLICATION FOR HPIX MEMBERSHIP AND INSURANCE

Name (First, Middle Initial, Last) \_\_\_\_\_

Home Address (Include City, State, Zip) \_\_\_\_\_

MD <input type="checkbox"/> DO <input type="checkbox"/>	Social Security Number:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Home Phone:	E-mail Address:	Date of Birth:
Business Phone:	Business Fax:	

**PREFERRED MAILING ADDRESS:**  Home  Principal Office  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)	Type Completed
2.	Hospital Name	State	Country	From (MM/DD/YY)	To (MM/DD/YY)	Type Completed
3.	Hospital Name	State	Country	From (MM/DD/YY)	To (MM/DD/YY)	Type Completed

Fellowship

Hospital Name	State	Country	From (MM/DD/YY)	To (MM/DD/YY)	Type 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
Pennsylvania			

- |   |  |
|---|--|
| 1. Has your medical license in any state ever been suspended, revoked or restricted?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you currently under investigation by any state licensing board or agency?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Fully explain any yes answer: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**COVERAGE HISTORY**

Previous professional liability insurers. List current insurer first.

Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
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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)?  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?  Yes  No  
 If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEMBERSHIP 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.  
 A copy of your current declarations page verifying retroactive date must be attached.

CLAIMS-MADE **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.

Under the *claims-made policy type*, coverage is limited to claims arising from the performance of professional services subsequent to the retroactive date stated in the declarations and first made against the company while the policy is in force. A reporting endorsement or equivalent coverage must be secured upon policy termination or nonrenewal.

OCCURRENCE

Under the *occurrence policy type*, coverage is provided for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is reported.

**PRACTICE INFORMATION**

1. What is your medical specialty? \_\_\_\_\_ Subspecialty ? \_\_\_\_\_
2. Are you board certified?  Yes  No  
 If no, are you board eligible?  Yes  No  
 If yes, when do you plan on taking your boards? \_\_\_\_\_  
 Specialty Board \_\_\_\_\_ Date Certified \_\_\_\_\_
- Have you ever failed a specialty/subspecialty exam? \_\_\_\_\_  
 Yes  No  
 Subspecialty Certificate \_\_\_\_\_ Date Certified \_\_\_\_\_

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	

Practice and hospital locations where you will practice subsequent to your desired date of coverage. List principal location first. Total of percentage of practice at all locations should equal 100%.

**PRACTICE LOCATIONS**

1. \_\_\_\_\_  
 Suite Number & Street City State Zip Code County % of Practice
2. \_\_\_\_\_  
 Suite Number & Street City State Zip Code County % of Practice
3. \_\_\_\_\_  
 Suite Number & Street City State Zip Code County % 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

1. Do you serve in a hospital emergency room for which you require HPIX coverage?  Yes  No  
 If yes, number of hours per week:  8 hours or fewer per week  Greater than 8 hours per week
2. Do you serve in a prison environment for which you require HPIX coverage?  Yes  No  
 If yes, number of hours per week:  8 hours or fewer per week  Greater than 8 hours per week

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**

- Multi-shareholder Corporation, Partnership, Limited
- Liability Corporation
- Government
- Hospital
- Industrial

Corporation, Partnership or Employer Name \_\_\_\_\_

Primary Office Contact Person: and Telephone Number \_\_\_\_\_

If this entity is not currently insured with HPIX, do you wish coverage?  Yes  No  
 If Yes, complete the Entity Liability Application

How many physicians and/or surgeons are in your group? \_\_\_\_\_ How many are applying to HPIX? \_\_\_\_\_

Do you (or does your entity) employ any paraprofessionals?  Yes  No  
 If yes, complete Section 1 below.

If you wish to purchase a separate set of basic limits of liability for any of these employees (referred to as Designated Employee Coverage), complete Section 2 below and attach a copy of employee's license and/or certification.

SECTION 1	
<i>Specialty</i>	<i>Number</i>
Nurses (RN and LPN)	
CRNAs	
Nurse Practitioners	
Nurse Midwives	
Physician Assistants	
Surgical Assistants	
Physical Therapists	
Medical or Lab Technicians	
Medical Assistants	
Other (specify)	

SECTION 2		
<i>Name and Specialty</i>	<i>Current Insurer</i>	<i>Retroactive Date</i>

Have any of your paraprofessional employees ever been named in a claim or suit?  Yes  No

Have any of your paraprofessional employees ever had any action taken against licensure?  Yes  No

If yes to either answer, complete the following (if additional space is required, photocopy this form as needed).

Employee Name: \_\_\_\_\_ Insurer: \_\_\_\_\_

Allegation: \_\_\_\_\_

Action Taken: \_\_\_\_\_

Status:  Open Reserves:  Closed without Payment  Closed with Payment - Amount: \_\_\_\_\_

**MEDICAL PROCEDURES**

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abortions                                 | <input type="checkbox"/> Hair Transplants         | <input type="checkbox"/> Pain Management                            |
| <input type="checkbox"/> Acupuncture                               | <input type="checkbox"/> Scalp Excision           | <input type="checkbox"/> Phenol Facial Peels                        |
| <input type="checkbox"/> Therapeutic                               | <input type="checkbox"/> Plug Technique           | <input type="checkbox"/> Polypectomy                                |
| <input type="checkbox"/> General Anesthetic                        | <input type="checkbox"/> In-Vitro Fertilization   | <input type="checkbox"/> Prenatal Care (other than first trimester) |
| <input type="checkbox"/> Anesthesia (General/Spinal/Caudal)        | <input type="checkbox"/> Interventional Radiology | <input type="checkbox"/> During second trimester                    |
| <input type="checkbox"/> Angioplasty                               | <input type="checkbox"/> Angiography              | <input type="checkbox"/> To term but do not deliver                 |
| <input type="checkbox"/> Assist in Major Surgery                   | <input type="checkbox"/> Arteriography            | <input type="checkbox"/> To term and deliver                        |
| <input type="checkbox"/> Own patients only                         | <input type="checkbox"/> Phlebography             | <input type="checkbox"/> Radiation or X-Ray Therapy                 |
| <input type="checkbox"/> Other than own patients                   | <input type="checkbox"/> Other _____              | <input type="checkbox"/> Radiopaque Dye Injection                   |
| <input type="checkbox"/> Biopsy by Aspiration                      | <input type="checkbox"/> Laparoscopy              | <input type="checkbox"/> Shock Therapy                              |
| <input type="checkbox"/> Other Biopsy                              | <input type="checkbox"/> Diagnostic               | <input type="checkbox"/> Sigmoidoscopy                              |
| Location _____   | <input type="checkbox"/> Cholecystectomy          | <input type="checkbox"/> Less than 50 cm                            |
| <input type="checkbox"/> Blepharoplasty                            | <input type="checkbox"/> Laser                    | <input type="checkbox"/> Greater than 50 cm                         |
| <input type="checkbox"/> Cosmetic _____ % of practice              | <input type="checkbox"/> Treatment                | <input type="checkbox"/> Skin Flaps/Grafts                          |
| <input type="checkbox"/> Reconstruction _____ % of practice        | <input type="checkbox"/> Surgery                  | <input type="checkbox"/> Cosmetic                                   |
| <input type="checkbox"/> Bone Fractures (closed treatment)         | <input type="checkbox"/> Lasik                    | <input type="checkbox"/> Reconstruction                             |
| <input type="checkbox"/> Bronchoscopy                              | <input type="checkbox"/> Liposuction              | <input type="checkbox"/> Telemedicine                               |
| <input type="checkbox"/> Cataract Surgery                          | <input type="checkbox"/> Lithotripsy              | <input type="checkbox"/> Tubal Ligation                             |
| <input type="checkbox"/> Catheterization                           | <input type="checkbox"/> Myelography              | <input type="checkbox"/> Vasectomy                                  |
| <input type="checkbox"/> Swan-Ganz                                 | <input type="checkbox"/> Nerve Blocks             | <input type="checkbox"/> Weight Control Medication                  |
| <input type="checkbox"/> Right Heart (other than CVP lines)        | <input type="checkbox"/> Facet                    | <input type="checkbox"/> C-Sections: How many annually? _____       |
| <input type="checkbox"/> Left Heart                                | <input type="checkbox"/> Lumbar                   | <input type="checkbox"/> Normal Obstetrical Deliveries              |
| <input type="checkbox"/> Colonoscopy                               | <input type="checkbox"/> Myofascial               | How many annually? _____  |
| <input type="checkbox"/> Cryosurgery (other than external lesions) | <input type="checkbox"/> Occipital                | <input type="checkbox"/> Other Medical Techniques                   |
| <input type="checkbox"/> D&C                                       | <input type="checkbox"/> Paravertebral            | List Procedures _____   |
| <input type="checkbox"/> Endoscopy                                 | <input type="checkbox"/> Triggerpoint Injection   | _____   |
| <input type="checkbox"/> ERCP                                      |   |   |

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. \_\_\_\_\_

3. Do you teach, supervise or proctor medical students, residents or fellows?  Yes  No  
 If yes, provide the number of hours per week. \_\_\_\_\_

4. Do you participate in clinical trials for any pharmaceutical or for any organization acting on behalf of a pharmaceutical?  Yes  No  
 If yes, describe. \_\_\_\_\_

5. SURGICAL ACTIVITIES. Check any of the following surgical activities applicable to your practice for which you require HPIX coverage and indicate the percentage of practice devoted to that activity:

- |  |                                |  |
|--|--------------------------------|--|
| _____ % Bariatric including Gastric Stapling | _____ % Orthopedic With Spine  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ % Colorectal                           | _____ % Plastic Cosmetic       | _____ % Cardiac  |
| _____ % Gynecology                           | _____ % Plastic Reconstruction | _____ % Thoracic   |
| _____ % Obstetric including C-Sections       | _____ % Hand                   | _____ % Vascular   |
|  | _____ % Neurosurgery           | _____ % Transplants                                      |

REMARKS. Use the space below for any comments that you feel will help HPIX better understand your practice.

**ADDITIONAL INFORMATION**

Fully explain any yes answer in the space provided below.

1. 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
2. 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?  
If yes, state the illness or disability and the date it occurred.  Yes  No
3. Have you ever been arrested for, charged with or convicted of a crime other than a minor traffic violation?  
If yes, provide details.  Yes  No
4. Do you own, operate or serve as an executive, administrative officer, medical director or department head for any hospital, nursing home, nonhospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization?  
If yes, indicate its name and describe your duties.  Yes  No
5. 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.)?  
If yes, indicate for whom you provide these services.  Yes  No
6. 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
7. Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action?  Yes  No

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8. Have you changed medical specialties within the past five years?  
If yes, complete the following chart.  Yes  No

Specialty	Insurance Carrier	Hours per Week	From	To

**CLAIMS HISTORY**

1. In the past ten years, has any malpractice claim or suit been made against you?  
If yes, how many? \_\_\_\_\_  Yes  No
2. Do you have knowledge of any incident, adverse outcome or other circumstances of clinical care of a patient that might reasonably lead to such a claim or suit?  Yes  No  
 If yes, how many? \_\_\_\_\_ Have they been reported to your previous insurers?  Yes  No  
 Physician self-reporting obligation: Have they been reported to the State Board of Medicine?  Yes  No

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

**ASSIGNMENT OF RIGHTS TO CANCEL COVERAGE**

I assign to my employer both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g., termination of coverage, classification change, etc.). However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to HPIX, 305 North Front Street, Fifth Floor, Harrisburg, PA 17101-1216.

Initial Here:

**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 and cooperate with a practice audit 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.

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: \_\_\_\_\_