Professional SOLUTIONS | INSURANCE COMPANY

Physicians and Surgeons Locum Tenens Application

A. APPLICANT INFORMATION

Name: ______________________________
First Name Middle Last Name

❑ Male ❑ Female Social Security No: ______________________ Date of Birth: ______________
MO/DAY/YR

Name of PSIC insured for whom you are substituting: ______________________________

Policy Number: ______________________________

Date of initial Locum Tenens Service: from 12:01 a.m. ______________ to 12:01 a.m. ______________

This application will stay on file for three years.

Locum Tenens coverage is a benefit provided to our insured. As the temporary substituting physician, the Locum Tenens understands and agrees that services provided must be similar to those provided by the PSIC insured physician. The substituting physician will share the limits of the PSIC insured physician.

B. EDUCATION

1. School of Graduation: ______________________ Degree: ______________ Year: __________

   ____
   City State County

2. Internship: ______________________________
   Name of facility City State

   Date completed: ______________
   MO/YR

3. Residency: ______________________________
   Name of facility City State

   Date completed: ______________
   MO/YR

4. Any additional training? ______________
   MO/YR

5. Are you a foreign medical graduate?.................................❑ Yes ❑ No

   If yes, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ....❑ Yes ❑ No

6. Are you certified by any approved specialty board(s)? ....❑ Yes ❑ No

   If yes, list each specialty below and attach each certification:

   Specialty: ______________________ *Date certified:* ______________
   MO/YR

   Specialty: ______________________ *Date certified:* ______________
   MO/YR

C. PRACTICE LOCATIONS

1. Please provide the requested information for practice locations in each separate state.

   State: ______________________ License No.: ______________________

   State: ______________________ License No.: ______________________

   State: ______________________ License No.: ______________________

Please provide a current CV.

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D. PRACTICE ACTIVITIES

1. Primary medical specialty: ___________________________% of practice: _______________

   If your medical specialty is not consistent with the PSIC insured's specialty, please describe the duties you will perform while substituting for the PSIC insured: ___________________________

   ____

2. Do you have a secondary medical specialty?..❑ Yes ❑ No

   *If yes, please list:*___________________________ *% of practice:* ________

3. Do you currently have malpractice insurance? ....❑ Yes ❑ No

   If yes, does your policy provide coverage to you while working as a locum tenens? ....❑ Yes ❑ No

4. Please provide the name of your current carrier: ___________________________

E. HISTORY

1. Please provide information on each professional liability insurer you have had for the last 10 years. *Please provide this information in chronological order.*

Dates	Insurer	Practicing Specialty	Limits of Liability	Coverage Type	Tail Coverage Purchased?	Any Claims?
				❑ Occurrence ❑ Claims Made	❑ Yes ❑ No	❑ Yes ❑ No
				❑ Occurrence ❑ Claims Made	❑ Yes ❑ No	❑ Yes ❑ No
				❑ Occurrence ❑ Claims Made	❑ Yes ❑ No	❑ Yes ❑ No

2. Are you now, or have you ever practiced without professional liability insurance?........................❑ Yes ❑ No
3. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? *Missouri residents, skip this question.* ....❑ Yes ❑ No
4. Has your medical license ever been investigated, denied, restricted, suspended, voluntarily surrendered or revoked in any state?........................❑ Yes ❑ No
5. Regarding your DEA certification, has it ever been restricted/put on probation, suspended or voluntarily surrendered? ....❑ Yes ❑ No
6. Have any complaints or actions been brought against you by any hospital? *(This includes restriction, suspension, revocation of privileges or probation.)*........................❑ Yes ❑ No
7. Have you ever been the subject of or are you aware of any future involvement in an investigation by a regulatory or peer review board? ....❑ Yes ❑ No
8. Have any complaints or claims been brought against you for sexual misconduct? ....❑ Yes ❑ No
9. Have you ever been accused of or been found to have altered healthcare records?........................❑ Yes ❑ No
10. Have you ever had a chronic physical limitation or mental/emotional illness or disorder which impairs or adversely impacts your practice of medicine? ....❑ Yes ❑ No
11. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics, or any other substance abuse? ....❑ Yes ❑ No

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E. HISTORY (continued)

12. Have you ever been charged, indicted or convicted; received a deferred prosecution or a deferred judgment and sentence; entered a guilty plea or a plea of nolo contendere; or been placed on adult diversion for any violation of any law? **Note:** You must answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted.
It is unnecessary to report traffic offenses that do not involve alcohol or drugs .... ❑ Yes ❑ No

13. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? .... ❑ Yes ❑ No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON THE LAST PAGE.

F. LOSS INFORMATION

1. In the past 10 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services?* ______________________ ❑ Yes ❑ No

   If yes, please indicate the number of each: Number of pending suits:__________ Number of closed claims:__________

2. Other than the situations indicated in Question 1 above, are you aware of any of the following:
   Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient?*.......... ❑ Yes ❑ No
   A letter from an attorney regarding your treatment of a patient?.......... ❑ Yes ❑ No
   A patient, family member or a patient representative's dissatisfaction with the outcome of a procedure, treatment or diagnosis?.......... ❑ Yes ❑ No
   Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit?.......... ❑ Yes ❑ No

3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier?**.......... ❑ N/A ❑ Yes ❑ No
   If yes, please attach a current loss run for each carrier, as appropriate.
   If no, please explain why these circumstances were not reported: ______________________

** For the purposes of this section the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.*

*** For the purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A CLAIM INFORMATION FORM.

G. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

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G. SIGNATURE REQUIRED (continued)

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

I understand and agree to the terms and conditions of coverage provided to this Locum Tenens physician in accordance with my policy.

For residents of all states except North Carolina: By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

For North Carolina residents: By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate.

For residents of all states except Oklahoma:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

______________________ Signature of Applicant	______________________ Date
______________________ Signature of PSIC Insured	______________________ Date
______________________ Signature of Agent	______________________ Date

Mail to:
14001 University Avenue
Clive, Iowa 50325-8258

Questions:
Phone: 800-788-8540
Fax: 800-510-6370

Email: submissions@psicinsurance.com

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