

LAMMICO

LOUISIANA PHYSICIANS AND SURGEONS

Application for Professional Liability Insurance

Please refer to www.lammico.com for a downloadable version of this application.

In order to allow adequate time for our underwriting review process, we ask that you please submit your application at least 30 days in advance of your requested effective date. Incomplete submissions or lack of required information will delay the underwriting process. After your application has completed the underwriting process, you will be promptly notified.

Please read the following instructions in order to expedite the review of your application:

1. Answer all questions or mark "N/A" where appropriate
2. Complete the attached Claim Addendum if a claim or suit has been filed against you
3. Submit a loss summary report from your previous carrier(s) – 10 years if applicable
4. Provide a copy of your current professional liability policy or declarations page
5. Provide a copy of your Curriculum Vitae
6. Sign and date your application

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (3) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

Once your application is received and reviewed, a member of the LAMMICO Board of Directors may interview you. Following your interview and subsequent underwriting review, you will be advised as to the status of your application.

If you have questions, please call the Underwriting Department at 504.831.3756 or 800.452.2120.

Thank you for your interest in LAMMICO. We look forward to serving your medical professional liability insurance needs.

When completed, please remit this application to:

LAMMICO
One Galleria Blvd., Suite 700
Metairie, LA 70001
FAX: 504.841.5205 or 504.841.5300



LOUISIANA PHYSICIANS AND SURGEONS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

Under the “**Claims-Made**” policy, 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. Under an “**Occurrence**” policy, 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.

Personal Information

				Application # (Lammico use only)				
Full Name (Last, First, Middle Initial)				Suffix <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> III <input type="checkbox"/> IV	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		NPI#	
Primary Practice Address (include city, state, zip)					Years at this location			
Mailing Address (include city, state, zip)					Other Locations (if any)			
Home Address (include city, state, zip)					Parish/County Medical Society			
Medical Group Name (if any)	Social Security No.	Date of Birth	Website Address		Email Address			
Office Phone	Fax Number	Home Phone			Cell Phone			

(Lammico Use Only)

Retroactive Date _____ Parish/County Code _____ Tax Code _____ Specialty/Class _____

Limit/Option _____ Discount Code _____ Discount _____ % Group Code _____

Start of Practice Date _____

Requested Effective Date: _____ / _____ / _____
MM DD YYYY

Professional Liability Limits Desired (please complete limits addendum)

Underwriting and Rating Information

1. Medical License Information: please list below:

State	License number	License Expiration Date	License Status

2. Has your license to practice medicine or narcotics license ever been revoked, voluntarily suspended, or subjected to probation/restrictions or are you aware of any circumstances that might lead to such? Yes No
 If yes, please describe: _____

3. State Narcotics / CDS License #: _____ Federal Narcotics / DEA License #: _____

4.

Undergraduate School, Location	Degree	Year Graduated
Medical School, Location	Degree	Year Graduated
Served Internship at (PG I)	Specialty	Dates Attended (mm/yy)
Served Residency at (PG II - ?)	Specialty	Dates Attended (mm/yy)
Fellowship or Postgraduate Training, Location	Specialty	Dates Attended (mm/yy)

5. Date you began practicing: _____
6. Are you a member of a state medical society? Yes No Specify state: _____
7. If a foreign medical school graduate, have you obtained an ECFMG Certificate or a Fifth Pathway Certificate? Yes No
 (a) Indicate which certification was obtained and year certified: ECFMG Fifth Pathway Year Certified: _____
8. Are you certified by an approved specialty board? (If yes, which?) _____ Yes No
 (a) Has there been a change in board status? (If yes, explain) _____ Yes No
9. How many continuing medical education credits did you achieve last year? _____
10. If you are coming from another state or country, please explain why: _____
11. What is your medical specialty? _____

Indicate percentage of time devoted to the following medical and/or surgical activities (total should equal 100%):

%	%	%	%
___ Addictionology	___ General Practice	___ Neurohospitalist	___ Pathology
___ Administrative Medicine	___ General Practice – Surgery	___ Neuro-radiology	___ Pediatrics
___ Aesthetic Medicine	___ General Preventive Medicine	___ Neurosurgery	___ Pharmacology – Clinical
___ Allergy	___ General Surgery	___ Neurosurgery-no intracranial	___ Physiatry – Phys. Med
___ Anesthesiology	___ Geriatrics	___ Nuclear Medicine	___ Psychiatry
___ Bariatric Medicine	___ Geriatrics/Institutional	___ Nutrition	___ Psychoanalysis
___ Bariatric Surgery	___ Gynecology	___ Obstetrics	___ Plastic Surgery
___ Cardiac Surgery	___ Gynecology – Surgery	___ Obstetrics/Gynecology	___ Pulmonary Diseases
___ Cardiothoracic Surgery	___ Hand Surgery	___ Occupational Medicine	___ Radiation – Oncologist
___ Cardiovascular Diseases	___ Head & Neck Surgery	___ Oncology – Medical	___ Radiology – Diagnostic
___ Cardiovascular Surgery	___ Hematology	___ Oncology – Surgery	___ Radiology – Therapeutic
___ Colon & Rectal Surgery	___ Hospitalist	___ Ophthalmology	___ Rheumatology
___ Dermatology	___ Infectious Diseases	___ Orthopedic – Ocular Plastic	___ Sleep Medicine
___ Emergency Medicine	___ Intensive Care Medicine	___ Ophthalmology – Surgery	___ Thoracic Surgery
___ Endocrinology	___ Internal Medicine	___ Orthopedic – Office Only	___ Trauma Surgery
___ Family Practice	___ Laborist	___ Orthopedic Surgery	___ Urgent Care Medicine
___ Family Practice-Incl. OB	___ Neonatology	___ Otorhinolaryngology	___ Urological Surgery
___ Family Practice-Surgery	___ Nephrology	___ Otorhinolaryngology/Plastic	___ Urology/Gynecology
___ Forensic Medicine	___ Nephrology Interventional	___ Otorhinolaryngology/Surgery	___ Vascular Surgery
___ Gastroenterology	___ Neurology	___ Pain Management	___ Wound Care

Additional Specialties: _____
 List any non-standard procedures you perform within or outside of your specialty: _____

12. Medical or Surgical Procedures (Please indicate whether you perform any of the following):
 Anesthesia General Spinal Epidural

Assisting in major surgical procedures

Minor Surgery & Procedures—Includes operations and procedures not considered to be major surgery, involving primary treatment of limited abnormalities, injuries, and infections of the skin and superficial tissue, usually using local anesthesia and predominantly performed on an outpatient basis. It includes but is not limited to the following list. Check all applicable:

NO PROCEDURES—only consulting or diagnostic

- Incisions of boils and superficial abscesses
- Suturing of skin and superficial fascia
- Acupuncture—other than acupuncture anesthesia
- Angiography
- Angioplasty
 - Coronary
 - Peripheral
 - Bone fractures: closed treatment
- Cancer chemotherapy
- Catheterization
 - Cardiac
 - Transarterial
 - Occasional insertion of pulmonary wedge, recording catheters, or temporary pacemakers
 - Transvenous
 - Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen (other than emergency or for transport)
- Cervical conization—specify type: _____
- Circumcision
- Colonoscopy
- Cosmetic injections—specify type: _____
- Cosmetic/reconstructive skin flaps and skin grafts
 - with arterial blood supply other than cancer therapy

- Cryosurgery
- On benign dermatological lesions
- Other: _____
- Dermabrasion
- Diagnostic sonography
- Discograms
- Electroshock therapy (psychiatric)
- Fiberoptic bronchoscopy
- Hair transplant
- Interventional endoscopy—specify type: _____
- Laser therapy—specify type: _____
- Myelography
- Needle biopsy
 - Lung, liver, kidney or prostate Breast
 - Other—specify type: _____
- Nerve blocks, therapeutic—specify type in “Remarks”
- Pain management—specify type in “Remarks”
- Pneumatic or mechanical esophageal dilation (not with bougie or olive)
- Radiopaque contrast material injections into veins, blood vessels, lymphatic, sinus tracts, and fistulae
- Radiopaque contrast material injections into arteries
- Radiation therapy
- Vasectomy
- Other: _____

Major Surgery—Includes operation procedures in or upon any body cavity including cranium, thorax, abdomen, pelvis; any other operations or procedures which, because of the condition of the patient or the length or circumstances of the operation, present a distinct hazard to life. It also includes but is not limited to the following list. Check all applicable:

- Amputations
- Bariatric/Obesity surgery—specify type: _____
- Bone fractures
 - Operative treatment Closed manipulation-general or regional anesthesia
- Fertility or reproductive surgery
- Gynecological procedures
 - Dilation and currettements other than emergency
- Laparoscopic Cholecystectomy
- Laparoscopy
 - Diagnostic Sterilization Therapeutic
- Liposuction—specify type, and if performed under general or local anesthesia: _____
- Minimal invasive endoscopic surgery—specify type: _____
- Obstetrical procedures
 - Abortions Cesarean sections Forceps delivery other than outlet forceps
 - Elective Home delivery
 - Therapeutic Vaginal delivery
 - Other: _____
- Penile implants
- Percutaneous disc surgery
- Plastic surgery
 - Cosmetic—specify type: _____ Breast augmentation/reduction
 - Reconstructive—specify type: _____
 - Facial—specify type: _____
- Radial keratotomy
- Spine surgery

<ul style="list-style-type: none"> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Spinal instrumentation 	<ul style="list-style-type: none"> <input type="checkbox"/> Primary <input type="checkbox"/> Reoperative <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Spinal instrumentation
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- Tonsillectomies and/or adenoidectomies
 - Other—specify type: _____

13. **Medical or Surgical Procedures** cont'd (Please indicate whether you perform any of the following):
 What percentage of your overall practice is devoted to treatment of chronic pain by prescribing controlled substances? ____%
If zero, please continue to question 14.
- (a) Do you have specialized training, qualifications and/or board certification in pain management? Yes No
 If yes, please describe: _____
 If no, please explain: _____
- (b) What pain management treatments do you utilize in your practice?
 (i.e. list medications prescribed, procedures performed, biofeedback, etc.) Please list all that apply: _____
- (c) What percent of your patients, being treated for pain management, are prescribed controlled substances? ____%
 How many controlled substance prescriptions do you dispense on a weekly basis? _____
- (d) Do you practice at a pain management clinic? Yes No
 If no, please continue to question 14.
- (e) Please list the name of the clinic: _____
 Is the clinic licensed to operate as a pain management clinic? Yes No
 Please attach a copy of the license.
- (f) If not licensed, please explain: _____
- (g) Physical address of the pain management clinic: _____
- (h) List the owner(s) of the pain management clinic: _____
- (i) Is there a pharmacy associated with the pain management clinic? Yes No
 If yes, please provide the name and location of the pharmacy: _____
- (j) How many hours per week do you work in a pain management clinic? _____
- (k) How many patients do you see weekly in a pain management clinic? _____
- (l) List all other physicians who practice at the pain management clinic: _____
- (m) Do you or the clinic advertise for pain management services? Yes No
 If yes, please provide copies of advertisements or marketing materials.
14. Do you provide care for federal/state prison or other correctional institution inmates? Yes No
 If yes, please list institution(s) in "Remarks."
 If yes, what percentage of your practice does this involve? ____%
- (a) Does the institution(s) cover you for this exposure? Yes No
 (If no, please forward copy of your contract with the institution so LAMMICO can determine if coverage can be provided.)
15. Do you provide care for inpatient nursing home or long-term care facility patients? Yes No
 If yes, what percentage of your practice does this involve? ____%
16. Do you provide care for any sports team or other athletic organization? Yes No
 If yes, what percentage of your practice does this involve? ____%
- (a) Does the team cover you for this exposure? Yes No
 (b) Do you travel outside of your primary state as part of your duties for the team? Yes No
 If yes, please explain in "Remarks."
 (c) Do you supervise any athletic trainers? Yes No
 If yes, please explain in "Remarks."
17. If you practice as a Radiologist, do you interpret mammograms? Yes No
 If yes, what percentage of your practice does this involve? ____%
 If yes, are they double-read by another radiologist? Yes No
18. Do you participate in experimental procedures, devices, drugs, therapy or clinical trials / research in treatment or surgery? If yes, please describe in "Remarks."
 If yes, do you follow FDA-approved protocols? If no, please describe in "Remarks."
 (a) Are you indemnified / held harmless by the clinical trial sponsor? Yes No
 If no, please explain: _____
 (b) Have you agreed to indemnify / hold harmless the clinical trial sponsor? Yes No
 If yes, please explain: _____
 (c) Is your role in the clinical trial within the scope of your medical specialty? Yes No
 If no, please explain: _____
19. Do you practice as a pulmonologist? Yes No
 If yes, do you also practice as an intensivist? Yes No
 If yes, what percentage of your practice does this involve? ____%
 (a) Do you accept primary responsibility for ICU patient care for patients other than your own patients? Yes No
 If yes, what percentage of your practice does this involve? ____%
20. Do you perform any coroner duties? If yes, please describe in "Remarks." Yes No
21. Does your practice include cosmetic/aesthetic procedures? If yes, please describe in "Remarks." Yes No
22. Do you provide laser/pulsed light procedures for cosmetic purpose? If yes, please describe in "Remarks." Yes No
 If yes, are these procedures performed under your direct on-site supervision? Yes No
 If no, please explain: _____

23. Practice / Ownership information:

(a) Practice Structure: (please check all that apply):

Practicing as:

- | | | |
|---|---|---|
| <input type="checkbox"/> Solo Practitioner | <input type="checkbox"/> Solo Corporation | <input type="checkbox"/> Independent Contractor |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Medical Partnership | <input type="checkbox"/> Member of a group practice |
| <input type="checkbox"/> Employer of other physicians | <input type="checkbox"/> Employed by another individual or corporate entity | |
| <input type="checkbox"/> Using a DBA or trade name | <input type="checkbox"/> Hospital Employee – Facility Name: _____ | |
| <input type="checkbox"/> Hospitalist – Facility Name: _____ | | |
| <input type="checkbox"/> Other – describe: _____ | | |

(b) Are you an owner or partner in a medical partnership, professional medical corporation or other business entity related to your practice of medicine? Yes No

If yes, please list each medical partnership, professional medical corporation or other business entity.

Name	Description of Interest	% of Practice

(c) Name each partner/shareholder who is insured by LAMMICO: _____

(d) Name each partner/shareholder who is not insured by LAMMICO: _____

(e) Is a medical corporation, partnership, or other entity to be added as an additional insured on your policy? Yes No

Question 23(e) does not apply to entities already covered for you by LAMMICO. If the answer to Question 23(e) is yes, please provide a copy of the Articles of Incorporation or Partnership Agreement for each entity that is to be covered.

(f) Do you want separate limits of liability for the entity? Yes No

(g) Are you in the employ of or under contract to any governmental entity? Yes No

If yes, provide a detailed explanation including a description of your responsibilities in "Remarks."

(h) Are you under contract to provide professional services to any individual, firm, corporation or athletic organization other than your own? If yes, please explain the details of your responsibilities in "Remarks." Yes No

24. Do you serve as a Medical Director? If yes, list in "Remarks" the facility name and your responsibilities. Yes No

25. Do you serve as a Medical Review Officer? If yes, please explain in "Remarks." Yes No

(Example: Do you evaluate/review lab results generated by an employer's drug-testing program?)

26. What call arrangements have you made and what are the qualifications of the person(s) taking your calls? _____

(a) Do you verify whether or not the person taking your calls purchases professional liability insurance? Yes No

27. Do you (or does your partnership/association/corporation/joint venture) employ, contract, or supervise any of the following:

*Status (E-employee, S-supervise only, I/C-independent contractor)

Yes	Status	How many?	Yes	Status	How Many?
<input type="checkbox"/> Aesthetician	_____	_____	<input type="checkbox"/> Optometrist	_____	_____
<input type="checkbox"/> Certified Nurse Midwife	_____	_____	<input type="checkbox"/> Perfusionist	_____	_____
<input type="checkbox"/> Chiropractor	_____	_____	<input type="checkbox"/> Pharmacist	_____	_____
<input type="checkbox"/> Clinical Nurse Specialist (CNS)	_____	_____	<input type="checkbox"/> Physical Therapist	_____	_____
<input type="checkbox"/> Lay Midwife	_____	_____	<input type="checkbox"/> Physician Assistant	_____	_____
<input type="checkbox"/> Nurse Anesthetist (CRNA)	_____	_____	<input type="checkbox"/> Podiatrist	_____	_____
<input type="checkbox"/> Nurse Practitioner	_____	_____	<input type="checkbox"/> Psychologist	_____	_____
<input type="checkbox"/> Surgical Assistant - specify type: _____	_____	_____	<input type="checkbox"/> RN First Assistant	_____	_____
<input type="checkbox"/> Other - description: _____	_____	_____			

NOTE: If you answered "yes" to any part of question 26, please list all names in the "Remarks" section. If you want to apply for insurance for these medical professionals through LAMMICO, please indicate in the "Remarks" section.

(a) Do you have a signed protocol agreement in place for any of the individuals referenced above? Yes No

If no, please explain: _____

(b) Do you have a signed Collaborative Practice Agreement with APRNs you supervise? Yes No

If no, please explain: _____

(c) Are the providers listed above currently covered by LAMMICO? Yes No

If covered elsewhere, please provide certificates of insurance.

(d) Are the providers listed above qualified with a state patient's compensation fund (e.g. LPCF)? Yes No

(e) Are the providers listed above independent contractors? Yes No

If yes, please list names and provide certificates of insurance: _____

(f) Do you supervise any individuals other than your employees? Yes No

If yes, please explain: _____

28. Describe your practice mix, e.g., surgical to non-surgical, city or rural, welfare or private pay, etc.: _____

29. Do you market, advertise, or practice medicine outside of your primary state? Yes No
If yes, list state(s) and explain: _____
30. Do you perform consultations outside of your primary state, including but not limited to the use of communications technology as the medium for rendering medical services, medical opinions or medical advice (**telemedicine or Internet medicine**)? Yes No
If yes, identify all states in which such patients reside: _____
If yes, what percentage of your practice is involved in such activities? ____%
31. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? Yes No
If yes, identify all states in which such patients reside: _____
32. Do you work in an emergency room on a scheduled basis? (If yes, please answer a and b below) Yes No
(a) Indicate number of hours per month devoted to hospital emergency room care: ____ hours per month
(b) Is this emergency room care: Yes No
On your own patients only? Yes No
Required for staff privileges Yes No
Other—please describe: _____
- (c) Are you requesting LAMMICO to cover you for ER work? Yes No
33. Do you perform major surgery in a freestanding facility (other than a hospital)? Yes No
If yes, please provide details in "Remarks."
34. Do you dispense drugs (other than free samples) in your office? Yes No
If yes, please list your State Dispensing number: State ____ Number _____ and outline your training and record keeping under "Remarks" section.
35. Do you anticipate changes in your practice or specialty in the next 12 months? Yes No
If yes, please describe: _____
36. Has there been any change in your practice or specialty in the past 10 years? Yes No
If yes, please describe: _____
37. Are you practicing: part-time semi-retired moonlighting another limited activity? Yes No
If yes, please describe the activity: _____
Number of **hours per month** the activity involves: _____

When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds.

NOTE: If you answer yes to any of the following questions, please give detailed information in the "Remarks" section of this application. (Attach additional sheets if necessary.)

38. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees? Yes No
39. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? Yes No
40. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? Yes No
41. Have you been treated for alcoholism, narcotic addiction or mental illness? Yes No
42. Have you volunteered to or been asked to participate in a physician's health (impaired) program? Yes No
43. Have Preceptor(s) or assisting physicians ever been assigned to your practice by a state licensing committee? Yes No
44. Have you now or have you ever had a chronic illness or physical limitation that impairs or could tend to impair your ability to practice medicine? Yes No
45. Have you been charged with or convicted of a crime (other than a minor traffic violation)? Yes No
46. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority? Yes No
47. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged, or has your professional liability insurer ever asked you not to renew your policy? Yes No
48. Has any insurance carrier ever declined to offer professional liability insurance to you? Yes No
49. Has any claim or suit for alleged malpractice ever been brought against you? Yes No
If yes, has this been reported to your present or prior insurer(s)? Yes No
50. Are you aware of any circumstances that might reasonably lead to a claim or suit? Yes No
If yes, has this been reported to your present or prior insurer(s)? Yes No

NOTE: If you answered yes to question 49 or 50, please provide the following information to complete and expedite our underwriting review:

1. For each claim, complete the attached CLAIM ADDENDUM
2. A copy of the petition filed against you, if available
3. If you think it will help in the evaluation of the claim, include a copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim

We may ask for additional information as needed. Please be as thorough as possible in order to expedite the review of your application.



51. List names of all professional liability insurance carriers that you have been insured with for the last 10 years, dates of coverage and reasons for change: _____

52. Why did you choose LAMMICO? _____

53. How many times have you changed your place of practice in the last 10 years, and what were the reasons for the changes? _____

54. What is your existing form of insurance? Claims-Made Occurrence None Carried

55. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement (“tail” coverage)? Yes No

(a) If no, are you applying for prior acts coverage from LAMMICO? Yes No

If no, I realize that not purchasing the “tail” from my current carrier can result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier’s policy. I understand that the policy I am purchasing from LAMMICO will not provide prior acts coverage.

Initial here _____

(LAMMICO may give consideration for prior acts. To see if you qualify, please submit a copy of your current policy showing the retroactive date and, if applicable, a current certificate of enrollment from your state patient’s compensation fund. Any claims or any circumstances that might reasonably lead to a claim or suit must be reported to your present carrier prior to the requested effective date of this insurance.

56. Retroactive date used by your existing carrier: _____

NOTE: To prevent possible gaps in your claims-made coverage, either a reporting endorsement (“tail”) or prior acts coverage must be purchased.

Question No.	Remarks (Attach additional sheets, if necessary)



Sign and date application in the space below.

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I understand that the statements and answers will be relied upon by LAMMICO and are material in determining not only whether insurance coverage will be issued or renewed, but also correct classification.

I hereby authorize release of my name, address, policy and premium information by LAMMICO to its agents or designees subject to confidentiality and nondisclosure agreements.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

_____ **Applicant Signature**

_____ **Date**

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application of insurance is guilty of a crime and may be subject to fines and confinement in prison.

LOUISIANA LIMITS ADDENDUM

Professional Liability Limits: (please check the limits desired)

Claims-Made:

- \$ 100,000 each medical incident / \$ 300,000 aggregate
- \$ 500,000 each medical incident / \$ 500,000 aggregate
- \$1,000,000 each medical incident / \$3,000,000 aggregate
- \$2,000,000 each medical incident / \$2,000,000 aggregate
- Higher Limits: Please refer to Company

Occurrence:

- \$100,000 each medical incident / \$300,000 aggregate



CERTIFICATES OF INSURANCE

List hospitals where you hold or are applying for staff privileges. Place an X in the box in front of each hospital requiring a certificate of insurance. Also list other entities (i.e., credentialing organizations, managed care entities, etc.) requiring certificates of insurance.

		Institution Code <small>(LAMMICO Use Only)</small>
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CLAIM/SUIT/COMPLAINT INFORMATION ADDENDUM

*If additional space is required, please photocopy this form as needed. Please type or print in black ink.
Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.*

Name of applicant: _____

Patient's Initials: _____ Age: _____ Sex: _____ Date of incident: _____
(MM/DD/YYYY)

Insurance company defending your claim: _____ Policy No. _____

Location of Incident: _____ City: _____ State: _____
(Hospital, Office, Etc.)

Procedures Performed: _____

Allegations and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.). If you already have a written narrative, please attach it to this form. Please attach a second sheet of paper if additional space is required.

Co-defendants: _____

Present Status

Medical review panel date: _____ Panel Opinion: Favorable Unfavorable Issue of Fact
Suit Filed: Yes No If yes: Month _____ Year _____
Court Trial: Yes No Verdict: Defense Verdict Plaintiff Verdict Amount: \$ _____
Settlement Out of Court: Yes No If yes: Month _____ Year _____ Amount: \$ _____

Claim settled without indemnity payment on your behalf Claim is pending Claim dismissed or withdrawn

Amount in reserve by insurance company \$ _____
Total amount paid to claimant on your behalf \$ _____
Total amount paid to claimant for all defendants \$ _____

The Applicant understands that the information submitted herein becomes part of the Professional Liability Application for insurance and declares that no material facts have been suppressed or misstated.

Applicant Signature in Full

Date