



Call Us Toll Free!
1(800) 361-8734

REQUESTED EFFECTIVE DATE: Month Day Year 12:01AM Policy Number _____
 COMPANY USE ONLY

PHYSICIAN'S PROFESSIONAL LIABILITY INSURANCE APPLICATION

[Click Here To Get Quick Online Medical Malpractice Insurance Price Indication](#)

I. GENERAL INFORMATION *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

A. APPLICANT PLEASE PRINT LEGIBLY YOUR POLICY IS BASED ON READABILITY OF YOUR APPLICATION

PLEASE ANSWER ALL QUESTIONS; IF A QUESTION IS NOT APPLICABLE, STATE "N/A".

Last Name			
First Name			
Middle Name		Suffix	
Degree	Date Of Birth	Social Security Number	- -

B. PRACTICE LOCATION(S) **PLEASE LIST PRINCIPAL LOCATION FIRST**

(COMBINED % OF PRACTICE FOR ALL LOCATIONS MUST TOTAL 100% & CAN NOT BE OF EQUAL VALUES)

Location # 1 % Of Your Practice	<input type="checkbox"/> Office <input type="checkbox"/> Hospital		
	<input type="checkbox"/> Admitting <input type="checkbox"/> Non-Admitting (If Non-Admitting Please Explain)		
	Practice/Hospital Name		
	Address:	City:	State: Texas
	County :	Zip Code:	

Location # 2 % Of Your Practice	<input type="checkbox"/> Office <input type="checkbox"/> Hospital		
	<input type="checkbox"/> Admitting <input type="checkbox"/> Non-Admitting (If Non-Admitting Please Explain)		
	Practice/Hospital Name		
	Address:	City:	State: Texas
	County :	Zip Code:	

Location # 3 % Of Your Practice	<input type="checkbox"/> Office <input type="checkbox"/> Hospital		
	<input type="checkbox"/> Admitting <input type="checkbox"/> Non-Admitting (If Non-Admitting Please Explain)		
	Practice/Hospital Name		
	Address:	City:	State: Texas
	County :	Zip Code:	



Call Us Toll Free!
1(800) 361-8734

C. RESIDENCE ADDRESS

Address:	City:	State: Texas
County :	Zip Code:	

D. BILLING AND CORRESPONDENCE ADDRESS

Same As Location # ____ Above Same As Residence Above Other Address (Specify)

Address:	City:	State: Texas
County :	Zip Code:	

E. CONTACT INFORMATION

Email Address:	
Business Tel. #:	Cell Tel. #:
Fax #:	Residence #:
<p><i>If we need to contact you for additional information, please indicate preferred method(s) of contact:</i></p> <p><input type="checkbox"/> Email <input type="checkbox"/> Business Tel. <input type="checkbox"/> Cell # <input type="checkbox"/> Residence # <input type="checkbox"/> Fax</p>	
Web Site :	

II. EDUCATIONAL BACKGROUND *If Additional Space Is Needed Use Supplemental Form*

A. MEDICAL SCHOOL

Name Of School:	
City:	State:
Country:	
Degree:	Completed From: Month Day Yr To: Month Day Yr

IF FOREIGN MEDICAL SCHOOL GRADUATE:

Are you certified by the educational commission for foreign medical graduates or have you completed the fifth pathway program? Yes No

If " NO" , Please Explain



B. RESIDENCY:

List All Resident Training Locations.

(i.e., residency specialty training, anesthesia residence training, ect.)

IF MORE THAN ONE SPECIALITY COMPLETED PLEASE ENTER EACH SPECIALTY

Location # 1	Name Of Hospital/Facility:						
City:	State:				Country:		
Specialty Type:							
Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	From: Month	Day	Yr	To: Month	Day	Yr	

Location # 2	Name Of Hospital/Facility:						
City:	State:				Country:		
Specialty Type:							
Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	From: Month	Day	Yr	To: Month	Day	Yr	

C. ADDITIONAL TRAINING:

(i.e., Fellowship, ect.)

HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? Yes No

Location # 1	Name Of Hospital/Facility:						
City:	State:				Country:		
Specialty Type:							
Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	From: Month	Day	Yr	To: Month	Day	Yr	

Location # 2	Name Of Hospital/Facility:						
City:	State:				Country:		
Specialty Type:							
Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	From: Month	Day	Yr	To: Month	Day	Yr	

D. EXPLAIN ANY GAPS IN CONTINUOUS TRAINING TIME PERIODS:

Have you had any gaps greater than 6 months between your medical school, residency, other training, or first time in private practice? Yes No

(If " Yes" Please Explain)

E. ARE YOU CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM?

Yes No



Call Us Toll Free!
1(800) 361-8734

IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE:

Month Day Yr

F. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME?

Yes No

G. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS?

Yes No If "Yes", How Many Category 1 Credit Hours?

H. HAVE YOU COMPLETED A RISK MANAGEMENT COURSE WITHIN THE LAST TWELVE (12) MONTHS?

Yes No

III. Practice Information *If Additional Space Is Needed Use Supplemental Form*

A. DO YOU PREFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? Yes No

If this is covered by another professional liability insurance policy, complete question 1 in section IV.

If "Yes", Which State(s):

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE:

			Exclude State Abbreviation				
1. State	Tx	License #		Active	Inactive	Temporary	Pending
2. State		License #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. State		License #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. State		License #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

C. PREVIOUS LOCATIONS OF PRACTICE:

LIST MOST RECENT LOCATION FIRST, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING

Location # 1	Name Of Practice:					
City:			State:		Country:	
Specialty Type:						
			From: Month	Day	Yr	To: Month
				Day	Yr	

Location # 2	Name Of Practice:					
City:			State:		Country:	
Specialty Type:						
			From: Month	Day	Yr	To: Month
				Day	Yr	



Call Us Toll Free!
1(800) 361-8734

Location # 3	Name Of Practice:					
City:	State:			Country:		
Specialty Type:						
	From:	Month	Day	Yr	To:	Month
						Day
						Yr

D. Please Explain Any Gaps Greater Than One Month Between Practice Locations:

E. To Which Medical Societies Or Associations Do You Belong? None

Name Of Societies / Association(s):

If None , Please Explain:

IV. RATING INFORMATION IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

NOTE: ALL PERCENTAGES REQUESTED BELOW FOR SPECIALTIES, PROCEDURES AND SURGICAL ACTIVITIES ARE OF YOUR TOTAL PRACTICE.

** Please enter complete Name Of Specialty / Sub-Specialty – Combined Percentages Must Equal 100% **

A. WHAT IS YOUR PRESENT SPECIALITY?

% Of Total Practice

B. ARE YOU PERMANENTLY RETIRED FROM PRACTICE OF CLINICAL MEDICINE?

Yes No

C. AMERICAN BOARD CERTIFIED? Yes No

1. If “Yes” Specify Specialty Board:

Date Certified: **Month** **Day** **Yr**

2. If “NO” Are You Board Eligible? Yes No

3. If “Yes” To Eligibility When Do You Plan To Take Boards? **Month** **Yr**

4. If “No” To Eligibility Have You Ever Taken A Specialty Board Exam & Failed To Pass? Yes No

If “Yes” Please Explain:

If You Failed Board Exam(s) , How Many Times:



Call Us Toll Free!
1(800) 361-8734

IV. RATING INFORMATION Continued

D. INDICATE THE AVERAGE WEEKLY NUMBER OF PATIENTS / HOURS WORKED / WALK-IN PATIENTS, UNDER EACH OF THE FOLLOWING CATEGORIES FOR WHICH YOU REQUIRE COVERAGE FOR.

State	Patients Seen Per Week	Hours Worked Per Week	Walk-In Patients Per Week
1. Texas			
2.			
3.			

*If you practice in multiple States, Please identify the following information for each State.
 If Additional Space In Needed Use Supplemental Form*

E. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU PREFORM:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominoplasty – Tummy Tuck | <input type="checkbox"/> Cryosurgery -non-external lesions | <input type="checkbox"/> Pacemakers – Epicardial |
| <input type="checkbox"/> Abortions- Elective
% of Your Total Practice | <input type="checkbox"/> D & C | <input type="checkbox"/> Pacemakers – Endocardial |
| <input type="checkbox"/> Abortions- Therapeutic
% of Your Total Practice | <input type="checkbox"/> Electromagnetic Therapy | <input type="checkbox"/> Pacemakers – Temporary |
| <input type="checkbox"/> Acupuncture – General Anesthetic | <input type="checkbox"/> Embolization | <input type="checkbox"/> Peritoneoscopy |
| <input type="checkbox"/> Acupuncture – Therapeutic / Local Anesthetic | <input type="checkbox"/> ERCP – Upper GI Endoscopy | <input type="checkbox"/> Phlebography |
| <input type="checkbox"/> Anesthesia General/Spinal/Caudal | <input type="checkbox"/> Face Lifts | <input type="checkbox"/> Pheumoencephalography |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Face Lifts Mini - done with laser
% of Your Total Practice | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Gastrointestinal Endoscopy | Prenatal / Gynecological Practice |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Gynecology – Major Surgery | <input type="checkbox"/> Prenatal Practice – 1 st & 2 nd Trimester |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Hair Transplants – Follicular Unit Transplantations | <input type="checkbox"/> Prenatal Practice – to term , no delivery |
| <input type="checkbox"/> Assisting in major surgery – own patients only | <input type="checkbox"/> Hair Transplants – Other | <input type="checkbox"/> Prenatal Practice – to term , and delivery |
| <input type="checkbox"/> Assisting in major surgery – own & other than own patients | <input type="checkbox"/> HVLA on the cervical spine on patients younger than 18 years of age | <input type="checkbox"/> Norm Deliveries – Total Per Year |
| <input type="checkbox"/> Bariatric Surgery – Laparoscopic | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Cersarean Deliveries – Total Per Year |
| <input type="checkbox"/> Bariatric Surgery – Non-Laparoscopic | <input type="checkbox"/> Laparoscopic Cholecystectomy | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Biopsy – Endoscopic | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Radial/Laser Keratotomy |
| <input type="checkbox"/> Blepharopigmentation
% of Your Total Practice | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Radiation/ X-Ray Therapy |
| <input type="checkbox"/> Blepharoplasty – Cosmetic
% of Your Total Practice | <input type="checkbox"/> Laser Therapy - Endoscopic | <input type="checkbox"/> Radiopaque Dye – Non Ionic Only |
| | | <input type="checkbox"/> Radiopaque Dye – Other Than Non Ionic |



Call Us Toll Free!
1(800) 361-8734

IV. RATING INFORMATION Continued

- | | | |
|---|---|--|
| <input type="checkbox"/> Blepharoplasty – Reconstruction
% of Your Total Practice | <input type="checkbox"/> Laser Therapy – Non-Endoscopic | <input type="checkbox"/> Rectal Ozone Therapy |
| <input type="checkbox"/> Botox
% of Your Total Practice | <input type="checkbox"/> Lipoinjection
% of Your Total Practice | <input type="checkbox"/> Rhinoplasty
% of Your Total Practice |
| <input type="checkbox"/> Brachioplasty | <input type="checkbox"/> Liposuction
<input type="checkbox"/> Other Than Tumescent Technique
<input type="checkbox"/> Tumescent Technique Only
% of Your Total Practice | <input type="checkbox"/> Shock Therapy |
| <input type="checkbox"/> Breast Implants - Cosmetic
% of Your Total Practice | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Sigmoidoscopy – 60 cm or less |
| <input type="checkbox"/> Breast Implants - Reconstruction
% of Your Total Practice | <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Sigmoidoscopy – greater than 60 cm |
| <input type="checkbox"/> Breast Reduction – Cosmetic | <input type="checkbox"/> Mammograms | <input type="checkbox"/> Silicone Injections
% of Your Total Practice |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Myelography | Skin Flaps/Grafts |
| <input type="checkbox"/> Bronco-esophagology | Nerve Blocks
<input type="checkbox"/> Facet
<input type="checkbox"/> Intrathecal Pumps
<input type="checkbox"/> Lumbar Epidural Steroid
<input type="checkbox"/> Myofascial
<input type="checkbox"/> Occipital
<input type="checkbox"/> Paraspinal
<input type="checkbox"/> Paravertebral
<input type="checkbox"/> Peripheral
<input type="checkbox"/> Sciatic
<input type="checkbox"/> Spinal Cord Stimulators
<input type="checkbox"/> Triggerpoint Injection | <input type="checkbox"/> Cosmetic
% of Your Total Practice
<input type="checkbox"/> Reconstruction
% of Your Total Practice
<input type="checkbox"/> Thigh Lift
<input type="checkbox"/> Tubal Ligations
<input type="checkbox"/> Vasectomies – own patients only
<input type="checkbox"/> Vasectomies – own & other than own patients
<input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Bottock Implants | | <input type="checkbox"/> Weight Control Medication
% of Your Total Practice |
| <input type="checkbox"/> Calf Implants | | <input type="checkbox"/> Other Medical Techniques |
| <input type="checkbox"/> Cataract Surgery | | List Procedures
(do not restate specialty) |
| <input type="checkbox"/> Catheterization – Left Heart | | 1. |
| <input type="checkbox"/> Catheterization – Right Heart
(other than CVP lines) | | 2. |
| <input type="checkbox"/> Catheterization – Swan-Ganz | | 3. |
| <input type="checkbox"/> Cheek/Chin/Lip Implants | <input type="checkbox"/> Oxidation Therapy | 4. |
| <input type="checkbox"/> Chelation Therapy | <input type="checkbox"/> | 5. |
| <input type="checkbox"/> Chemical Peels – Superficial | <input type="checkbox"/> | |
| <input type="checkbox"/> Chemical Peels – Medium | <input type="checkbox"/> | |
| <input type="checkbox"/> Chemical Peels – Deep
% of Your Total Practice | <input type="checkbox"/> | |
| <input type="checkbox"/> Cleft Lip Surgery – Reconstructive | | |
| <input type="checkbox"/> Cleft Palate Surgery – Reconstructive | | |
| <input type="checkbox"/> Colonoscopy | | |
| <input type="checkbox"/> Cryosurgery (Cervical) | | |



Call Us Toll Free!
1(800) 361-8734

IV. RATING INFORMATION Continued

F. INDICATE THE PERCENTAGE OF YOUR TOTAL PRACTICE DEVOTED TO THE FOLLOWING ACTIVITIES:

% CARDIAC	% ORTHOPEDIC – INCLUDING BACK	% TRAUMATIC
% GYNECOLOGY	% ORTHOPEDIC – NOT INCLUDING BACK	% UROLOGY
% HAND	% OTORRHINOLARYNOLOGY	% VASCULAR
% NEUROSURGERY	% PLASTIC – COSMETIC ENHANCEMENT ONLY	
% OBSTETRICS	% PLASTIC – RECONSTRUCTIVE ONLY	% Other -Please Describe 1.
% OPHTHALMOLOGY	% THORATIC	

G. IN THE LAST TEN (10) YEARS,

1. Have You Discontinued Major Surgical Procedures, Performance Of Obstetrics, Or Any Other Medical Activity? Yes No

If “Yes” Please Provide Month Yr

List Procedures / Activities / Date & Reason For Discontinuing:

2. Have You Performed Weight Control Surgery Or Prescribed Weight Control Medication?

Yes No

a. If “Yes”, What percentage of your practice patient care was devoted to prescribing anorectic drugs?

Never Prescribe Weight Control Medication < 1 % 1% - 10 % 11% - 50 % > 50 %

b. If “Yes”, What percentage of your practice patient care was devoted to performing weight control surgery?

Never Performed Weight Control Surgery < 1 % 1% - 10 % 11% - 50 % > 50 %

3. Do You Have Ownership In A Weight Control Clinic? Yes No

If “Yes” What is the name of the weight control clinic with which you are affiliated?



Call Us Toll Free!
1(800) 361-8734

IV. RATING INFORMATION Continued

H. DO YOU SERVE IN A HOSPITAL EMERGENCY ROOM FOR WHICH YOU REQUIRE COVERAGE? Yes No

1. If "Yes", Number Of Hours Per Month (Excluding "On-Call Hours)

2. If "Yes", Are The Hours You Work In The ER The Minimum Number Of Hours Required To Maintain Hospital Privileges? Yes No

IF YOU HAVE EMERGENCY ROOM ACTIVITIES WHICH ARE COVERED BY ANOTHER PROFESSIONAL LIABILITY INSURANCE POLICY, COMPLETE QUESTION I BELOW.

I. WILL YOU BE PERFORMING ACTIVITIES WHICH WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY? Yes No

1. If "Yes", Complete the following :

Employee Independent Contractor Resident/Fellow Faculty

2. If "Yes", Provide Practice Name/ Location(s) Carrier Name :

J. PLEASE USE THE SPACE BELOW FOR ANY COMMENTS YOU FEEL WILL HELP OUR UNDERWRITERS BETTER UNDERSTAND ANY SPECIAL CIRCUMSTANCES CONCERNING YOUR PRACTICE.

COMMENTS:



Call Us Toll Free!
1(800) 361-8734

V. ADDITIONAL PROFESSIONAL INFORMATION

PLEASE FULLY EXPLAIN ANY "YES" ANSWERS TO THE BELOW QUESTIONS ON THE SUPPLEMENTAL FORMS LOCATED AT THE LAST PAGE OF THIS APPLICATION.

IF YOU PARTICIPATE IN ANY ACTIVITIES LIST BELOW WHICH ARE COVERED BY ANOTHER PROFESSIONAL LIABILITY INSURANCE POLICY, COMPLETE THE ABOVE SECTION IV. QUESTION I..

A. DO YOU PERFORM SURGERY ON OR ARE YOU A TEAM PHYSICIAN FOR ANY PROFESSIONAL OR COLLEGIATE ATHLETES? Yes No

If "Yes" What Percentage Of Your Practice Is Devoted To This Activity? %

B. DO YOU PARTICIPATE IN PHARMACEUTICAL TESTING PROGRAMS / CLINICAL INVESTIGATION STUDIES THAT ARE NOT FDA APPROVED? Yes No

If "Yes", furnish us a copy of the indemnification agreement provided by the pharmaceutical company.

C. DO YOU PARTICIPATE IN A NURSING HOME FACILITY? Yes No

If "Yes" What Percentage Of Your Practice Is Devoted To This Activity? %

D. DO YOU TREAT OR REVIEW TREATMENT OF FEDERAL PRISON INMATES? Yes No

E. DO YOU TREAT NON-FEDERAL PRISON INMATES? Yes No

If "Yes" What Percentage Of Your Practice Is Devoted Treating Non-Federal Inmates? %

Does This Facility Have A Law Library? Yes No

F. DO YOU USE A COLLECTION AGENCY WHICH HAS THE AUTHORITY TO FILE COLLECTION SUITS WITHOUT YOUR KNOWLEDGE? Yes No

If "Yes" Please Explain:

G. DO YOU PRACTICE AS A MEDICAL DIRECTOR? Yes No

1. If "Yes" What Is Type Business & Name Employer / Facility Name :

2. Briefly Describe Your Responsibilities:



H. DO YOU DEVISE OR REVIEW PLANT / EMPLOYER SAFETY STANDARDS?

Yes No

1. What Products Are Manufactured By The Company?

2. Name Of Company:

. Location:

I. HAVE YOU EVER BEEN INDICTED FOR, CHARGED WITH, OR CONVICTED OF, ANY ACT COMMITTED IN VIOLATION OF ANY LAW OR ORDINANCE OTHER THAN TRAFFIC OFFENSES OR HAD YOUR HOSPITAL PRIVILEGES, DEA LICENSE, MEDICAL LICENSE OR REINBURSEMENT PRIVILEGES REFUSED, DENIED, REVOLKED, SUSPENDED, RESTRICTED, SUBJECT TO A REPRIMAND, PLACED ON PROBATION OR VOLUNTARILY SURRENDERED? Yes No

If "Yes" What Date: **Month** **Day** **Yr**

If "Yes" Please Explain :

J. HAS ANY PROFESSIONAL LIABILITY INSURANCE COMPANY EVER DECLINED, REFUSED, CANCELED, OR NOW RENEWED YOU COVERAGE, OR HAVE YOU EVER HAD AN INVOLUNTRAY DEDUCTIBE OR SURCHARGE ASSESSED AGAINST YOUR POLICY? Yes No

If "Yes" What Date: **Month** **Day** **Yr**

If "Yes" Please Explain :

K. HAVE YOU EVER BEEN ACCUSED OF SEXUAL MISCONDUCT OF ANY KIND?
 Yes No

If "Yes" What Date: **Month** **Day** **Yr**

If "Yes" Please Explain :



Call Us Toll Free!
1(800) 361-8734

L. HAVE YOU INCURRED OR BECOME AWARE OF HAVING A CONDITION THAT IMPAIRS YOUR ABILITY TO PRACTICE YOUR MEDICAL SPECIALTY?

Yes No

(i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics or other controlled substances, etc.)

If “ Yes” State condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **A STATEMENT FROM YOUR PHISICAN ATTESTING TO YOUR FITNESS TO PRACTICE YOUR SEICIALITY MUST ACCOMPNAV THIS APPLICATION.**

Further statements may be requested as necessary by the company to complete the underwriting of your application.

Type Of Illness :

Duration Of Illness: **From:** Month Day Yr **To:** Month Day Yr

Treating Physician (Name & Address) :

VI. PRACTICE ORGANIZATION INFORMATION IF NECESSARY, USE SUPPLEMENTAL FORM

A. INDICATE THE NUMBER OF EACH OF THE FOLLOWING WHO PROVIDE SERVICES IN YOUR OFFICE (PLEASE INCLUDE YOURSELF) :

PHYSICIANS	NURSE MIDWIFE ASSITANTS	PHYSICAN SURGICAL ASSISTANTS
DENTIST	NURSE PRACTITIONERS	PODIATRISTS
CASE MANAGERS	NURSE SURGICAL ASSITANTS	PSHYCHOLOGISTS
CRNAs/RBAs	OCCUPATIONAL THERAPISTS	RESPIRATORY THERAPISTS
CHIROPRACTORS	PERFUSIONIST	
NURSE MIDWIVES	PHYSICAN ASSISTANTS	

B. DO YOU OR ANY MEMBER OF YOUR GROUP CURRENTLY SUPERVISE ANY OF THE SPECIALISTS LISTED ABOVE WITH WHOM YOU DO NOT EITHER EMPLOY OR CONTRACT FOR SERVICES? Yes No

If “No” Are You Planning To Do So In The Near Future? Yes No

If You Are Not Planning To Do So Then Please Explain :



Call Us Toll Free!
1(800) 361-8734

C. PRACTICE ORGANIZATION:

PLEASE CHECK THE BOXES BELOW THAT BEST DESCRIBE YOUR PRACTICE AFFILIATION(S) AND CHECK (“X”) ANY APPLICABLE BOXES UNDER EMPLOYMENT STATUS.

ONE OR MORE BOXES MAY BE CHECK – WITH AT LEAST A MINMIUM OF ONE BOX

NOTE: TO SECURE COVERAGE FOR AN ENTITY (i.e., Corporations ,LLC’s LLP’s) YOU WILL NEED TO COMPLETE AN ENTITY APPLICATION FOR UNDERWRITING CONSIDERATION

<input type="checkbox"/> SOLO UNINCORPORATED PRACTITIONER / SOLE PROPRIETOR
INDIVIDUAL PHYSICIAN'S DBA PRACTICE NAME:
YOUR EMPLOYMENT STATUS WITHIN THIS ORGANIZATION <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other If “Other” Please Explain:
Date Joined/Formed: Month Yr

<input type="checkbox"/> SOLO INCORPORATED
ENTITY NAME:
YOUR EMPLOYMENT STATUS WITHIN THIS ORGANIZATION <input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other If “Other” Please Explain:
Date Joined/Formed: Month Yr
Is this entity or employer currently insured under a group professional liability policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If “Yes”, Please provide the employer practice or entity name: If “Yes”, Please provide the insurer name , policy number , group number , sub-group number (if applicable) for the: Insurer: Policy #: Group #: Sub-Group #: If “No”, Do You Wish To Get Coverage For This Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No



Call Us Toll Free!
1(800) 361-8734

VI. PRACTICE ORGANIZATION INFORMATION - CONTINUED

<input type="checkbox"/> MULTI-SHAREHOLDER CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY			
ENTITY NAME:			
YOUR EMPLOYMENT STATUS WITHIN THIS ORGANIZATION			
<input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other			
If "Other" Please Explain:			
Date Joined/Formed: Month		Yr	
Is this entity or employer currently insured under a group professional liability policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", Please provide the employer practice or entity name:			
If "Yes", Please provide the insurer name , policy number , group number , sub-group number (if applicable) for the:			
Insurer:	Policy #:	Group #:	Sub-Group #:
If "No", Do You Wish To Get Coverage For This Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<input type="checkbox"/> HOSPITAL <input type="checkbox"/> INDUSTRIAL <input type="checkbox"/> GOVERNMENT - Enter Branch :			
ENTITY NAME:			
YOUR EMPLOYMENT STATUS WITHIN THIS ORGANIZATION			
<input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other			
If "Other" Please Explain:			
Date Joined/Formed: Month		Yr	
Is this entity or employer currently insured under a group professional liability policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", Please provide the employer practice or entity name:			
If "Yes", Please provide the insurer name , policy number , group number , sub-group number (if applicable) for the:			
Insurer:	Policy #:	Group #:	Sub-Group #:
If "No", Do You Wish To Get Coverage For This Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No			



Call Us Toll Free!
1(800) 361-8734

VI. PRACTICE ORGANIZATION INFORMATION - CONTINUED

<input type="checkbox"/> STATE LICENSED MEDICAL SURGERY CENTER: (If You Checked The Above Box Please Indicated Use Below) <input type="checkbox"/> <i>STATE MEDICAL FACILITY OPERATED FOR USE BY OTHER PHYSICANS</i> <input type="checkbox"/> <i>STATE MEDICAL FACILITY OPERATED FOR USE BY YOUR PATIENTS ONLY</i>
ENTITY NAME:
YOUR EMPLOYMENT STATUS WITHIN THIS ORGANIZATION <input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other If "Other" Please Explain:
Date Joined/Formed: Month Yr
Is this entity or employer currently insured under a group professional liability policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Please provide the employer practice or entity name: If "Yes", Please provide the insurer name , policy number , group number , sub-group number (if applicable) for the: Insurer: Policy #: Group #: Sub-Group #:
If "No", Do You Wish To Get Coverage For This Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> OTHER TYPE MEDICAL OFFICE PRACTICE / FACILITY / CENTER If "Other", Please Explain:
ENTITY NAME:
YOUR EMPLOYMENT STATUS WITHIN THIS ORGANIZATION <input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other If "Other" Please Explain:
Date Joined/Formed: Month Yr
Is this entity or employer currently insured under a group professional liability policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Please provide the employer practice or entity name: If "Yes", Please provide the insurer name , policy number , group number , sub-group number (if applicable) for the: Insurer: Policy #: Group #: Sub-Group #:
If "No", Do You Wish To Get Coverage For This Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No



Call Us Toll Free!
1(800) 361-8734

VI. PRACTICE ORGANIZATION INFORMATION - CONTINUED

D. IF THE BUSINESS PURPOSE OF THE ENTITY NOTED ABOVE IS OTHER THAN A MEDICAL OFFICE PRACTICE, PLEASE EXPLAIN BELOW:

VII. LOSS INFORMATION *IMPOTANT- FULLY COMPLETE - IF NECESSARY, USE SUPPLEMENTAL FORM*

PLEASE COMPLETE THE CLAIM/SUIT INFORMATION, SECTION VIII, FOR EACH CLAIM OR LAW SUIT FILED / REPORTED , OR PROTENTIAL CLAIM OR LAW SUIT.

- A. ARE YOU NOW, OR HAVE YOU EVER BEEN INVOLVED, DIRECTLY OR INDIRECTLY, IN A CLAIM, POTENTIAL CLAIM, OR LAW SUIT ARISING OUT OF THE RENDERING OF FAILURE TO RENDER PROFESSIONAL SERVICES? Yes No If "Yes", How Many?**

- B. ARE YOU AWARE OF ANY COMPLICATION, INCIDENT OR UNEXPECTED ADVESRE OUTCOME RESULTING IN INJURY OR DEATH, THAT MIGHT REASONABLY BE EXPECTED TO RESULT IN A CLAIM OR LAW SUIT BEING MADE AGAINST YOU? Yes No If "Yes", How Many?**

- C. IN THE LAST 12 MONTHS, HAVE YOU, OR ANYONE FROM YOUR PRACTICE, RECEIVED A WRITTEN REQUEST FROM AN ATTORNEY, FOR TREATMENT RECORDS, CONCERNING ANY OF YOUR CURRENT OR FORMER PATIENTS? Yes No**



Call Us Toll Free!
1(800) 361-8734

If “Yes To C. Above”, Did any of the requests for records pertain to a patient who suffered an unexpected, adverse outcome, including, but not limited to, any of the following:

<input type="checkbox"/> AMPUTATION If “Yes”, How Many?	<input type="checkbox"/> LOSS OF MAJOR ORGAN FUNCTION If “Yes”, How Many?	<input type="checkbox"/> PERMANENT NEUROLOGICAL INJURY If “Yes”, How Many?
<input type="checkbox"/> DEATH If “Yes”, How Many?	<input type="checkbox"/> LOSS OF VISION If “Yes”, How Many?	

VII. CLAIM/LAW SUIT INFORMATION IF NECESSARY, USE SUPPLEMENTAL FORM

Note: ADDITIONAL DOCUMENTION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING INSURERS DISCRETION, ALL FIELD BELOW MUST BE COMPLETED.

A. Patient/Claimant Information: Age:		
Last Name:	First Name:	Middle Initial:
B. Date of treatment and/or surgery, which led to the allegations against you:		
From: Month	Day	Yr
To: Month	Day	Yr
C. Date claim/incident notice received: Month Yr		
D. Has this claim/incident been reported to your current or former insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If “Yes”, Date claim reported to your current or former insurer: Month Yr		
<i>If “Yes”, Please provide copy of the report(s)</i>		
E. Name of other doctor(s), hospital(s) , or health care provider(s), if any, involved in the claim or law suit:		
F. Disposition or current status of claim or suit : <input type="checkbox"/> Open <input type="checkbox"/> Closed		
If “Closed”, Date of closing/settlement or award : Month Yr		
G. Indicate pending case dollar value established by your insurer, if known : \$		
Defending insurer’s name :		
H. Was this matter closed with your consent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was a formal claim made or law suit filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was Payment Made? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If “No”, Was claim or suit withdrawn? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If “Yes”, Indicate total dollar amount of settlement or award: \$		
Amount paid on your behalf: \$		



VII. CLAIM/LAW SUIT INFORMATION - CONTINUED

I. Nature of allegations in the claim or law suit :

Condition Treated :

Treatment Provided:

Alleged Negligence:

Alleged Injury:

K. Please Provide A Narrative Description Of The Medical Facts:

(Including but on limited to the type of treatment and/or surgery; with your involvement)



Call Us Toll Free!
1(800) 361-8734

IX. COVERAGE INFORMATION IF NECESSARY, USE SUPPLEMENTAL FORM

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING.

List Current Insurer First:

INSURER	TYPE COVERAGE	TRAINING DATES
1.	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	From: Month Day Yr To: Month Day Yr
2.	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	From: Month Day Yr To: Month Day Yr
3.	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	From: Month Day Yr To: Month Day Yr
4.	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	From: Month Day Yr To: Month Day Yr
6.	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	From: Month Day Yr To: Month Day Yr

Please explain below if any gaps in coverage back to your start date of practice have occurred:

B. COVERAGE REQUESTED:

1. Occurrence
2. Claims-Made Without Prior Acts Coverage
3. Claims-Made With Prior Acts Coverage

(For prior acts coverage copy of current policy declarations showing retroactive date must be attached)

CLAIMS-MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD, FOR SERVICES RENDERED BETWEEN THE RETROACTIVE DATE AND EXPIRATION DATE OF THE POLICY. PLEASE CONTACT YOUR AGENT SHOULD YOU HAVE ANY QUESTIONS PERTAINING TO THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE OR THE ADDITIONAL EXPENSE ASSOCIATED WITH AN "EXTENSION CONTRACT" OR "TAIL COVERAGE."

If 1 or 2 above are selected and the most recent prior coverage was issued on a claims made basis, please complete one of the following:

- a. An Extended Reporting Endorsement (Tail Coverage) Has Been Purchased – *Must Attach Copy*
- b. An Extended Reporting Endorsement (Tail Coverage) Has NOT & WILL NOT Be Purchased



Call Us Toll Free!
1(800) 361-8734

IX. COVERAGE INFORMATION - Continued

If I checked "b." above ,I understand I WILL NOT purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current professional liability insurance carrier will result in an uninsured exposure fro nay claims which may arise as a result of professional services rendered while insured by my current carrier’s policy. I understand that the policy, for which I am applying for with your company, if offered will not provide prior acts coverage;

I Have Here By Entered My Initials As Acknowledgement That I Have Read & Understand That I Will Not Have Prior Acts Coverage:

ENTER YOUR INITIALS HERE

C. REQUESTED COVERAGE EFFECITVE DATE 12:01 A.M.

From: Month Day Yr

To: Month Day Yr

*NOTE: Annual Policy Terms Will Begin And End On The Same Month & Day.
 (If your are joining an existing insured/group , your coverage may be issued to a common expiration date)*

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:

Month Day Yr (Not required for occurrence policies or claims-made without prior acts)

E. COVERAGE LIMITS REQUESTED

<input type="checkbox"/>	\$ 100,000 Per Occurrence/ Per Claim - \$ 300,000 Annual Aggregate
<input type="checkbox"/>	\$ 200,000 Per Occurrence/ Per Claim - \$ 600,000 Annual Aggregate
<input type="checkbox"/>	\$ 500,000 Per Occurrence/ Per Claim - \$ 1,000,000 Annual Aggregate
<input type="checkbox"/>	\$ 500,000 Per Occurrence/ Per Claim - \$ 1,500,000 Annual Aggregate
<input type="checkbox"/>	\$ 1,000,000 Per Occurrence/ Per Claim - \$ 1,000,000 Annual Aggregate
<input type="checkbox"/>	\$ 1,000,000 Per Occurrence/ Per Claim - \$ 3,000,000 Annual Aggregate
<input type="checkbox"/>	\$ 2,000,000 Per Occurrence/ Per Claim - \$ 2,000,000 Annual Aggregate
<input type="checkbox"/>	\$ 2,000,000 Per Occurrence/ Per Claim - \$ 4,000,000 Annual Aggregate
<input type="checkbox"/>	\$ 2,000,000 Per Occurrence/ Per Claim - \$ 5,000,000 Annual Aggregate
<input type="checkbox"/>	\$ 3,000,000 Per Occurrence/ Per Claim - \$ 3,000,000 Annual Aggregate
<input type="checkbox"/>	\$ 3,000,000 Per Occurrence/ Per Claim - \$ 5,000,000 Annual Aggregate
<input type="checkbox"/>	Other Specify \$ _____ Per Occurrence/ Per Claim - \$ _____ Annual Aggregate

NOTE: YOUR REQUESTED LIMITS MAY NOT BE AVIALA BLE WITH ALL INSURERS.



Call Us Toll Free!
1(800) 361-8734

X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

BY INITIALIZING BELOW, I ASSIGN TO THE FOLLOWING EMPLOYER OR NAMED PARTY-

Practice/Hospital Name		
Address:	City:	State:
County :	Zip Code:	

ENTER YOUR INITIALS HERE

BOTH THE RIGHT TO CANCEL MY POLICY AND TO RECEIVE ANY UNEARNED PREMIUM, HOWEVER, I DO REQUEST THAT COPIES OF ALL CORRESPONDENCE, FORMAL NOTICIES, ECT. BE SENT ME AT THE LAST ADDRESS OF RECORD. THIS ASSINGNEMENT MAY BE REVOLKED MY ME AT ANY TIME BY SENDING WRITTEN NOTICE TO THE INSURANCE COMPANIES HOME OFFICE.

NOTE: Your Right To Cancel And receive Any Premium Refund Will Automatically Be Assigned:

1. To The First Named Insured If You Are Covered Under A Group Policy.
2. To A Third Party Finance Company If It Pays Your Premium On Your Behalf.

XI. STATE STATUTORY REQUIREMENT

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY FILES AN APPLICATION FOR INSRUANCE 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 AS CRIME AND ALSO PUNISHABLE BY CRIMINAL AND/OR CIVIL PENALTIES IN CERTAIN JURISDICTIONS.

ENTER YOUR INITIALS HERE



Call Us Toll Free!
1(800) 361-8734

XI. APPLICANT'S SIGNATURE – Please Read , Sign, & Date

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT I HAVE NOT KNOWINGLY SUPPRESSED OR MISSTATED ANY MATERIAL FACTS AND I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY, I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN MY PROFESSIONAL SPECIALITY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY OTHER PHYSICIAN , DENTIST, FIRM, OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT A MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER MY CONTRACT FOR INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT, BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT I HAVE NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED MY COMPLETED APPLICATION; (2) OFFERED ME A FINAL PREMIUM QUOTE; (3) ISSUED A WRITTEN APPROVAL OF MY APPLICATION ALONG WITH A INITIAL BINDER OF COVERAGE AND (4) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE , IN ADDITION, I UNDERSTAND THAT IF I PAY MY FIRST INSTALLMENT BY CHECK, ELECTRONIC TRANSFER, OR MONEY ORDER IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS I WILL HAVE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYEES, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER ENTITIES TO VERIFY ANY INFORMATION AND/OR ASCERTAIN INFORMATION REGARDING MY CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND IF ISSUED, AFTER ISSUANCE OF A CONTRACT OR INSURANCE, THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REGARDING MY APPLICATION, WHICH THE COMPANY , IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

DATE SIGNED: Month Day Yr

APPLICANT'S SIGNATURE: _____

Print Name: _____

IF APPLICATION IS BEING SIGNED BY THE APPLICANT'S AGENT:

BY MY SIGNATURE, I HEREBY REPRESENT THAT THE APPLICANT HAS GRANTED ME FULL AUTHORITY TO EXECUTE THIS APPLICATION ON HIS OR HER BEHALF. I ALSO REPRESENT THAT I HAVE REVIEWED THE RESPONSES CONTAINED IN THE APPLICATION WITH THE APPLICANT, AND WE ARE IN AGREEMENT THEY ARE FULL AND COMPLETE TO THE BEST OF OUR COMBINED KNOWLEDGE AND BELIEF. IN ADDITION, I REPRESENT THAT I HAVE DISCUSSED THE REPRESENTATIONS PROVIDED THROUGHOUT THIS APPLICATION WITH THE APPLICANT AND THAT THE APPLICANT UNDERSTANDS AND AGREES THAT SUCH REPRESENTATIONS ARE BINDING UPON HIMSELF OR HERSELF, EVEN THOUGH I AM EXECUTING THIS APPLICATION ON THE APPLICANT'S BEHALF, I FURTHER ACKNOWLEDGE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY FORM A BASIS OF THE COMPANY TO TERMINATE MY AGENCY AGREEMENT WITH CAUSE.

DATE SIGNED: Month Day Yr

AGENT'S SIGNATURE: _____

Print Name: Edwin (Ed) L . Hemphill ,CIC

Hemphill Insurance Agency dba www.TheIndependentInsuranceAgency.com
3833 Windswept / P.O. Box 767 Montgomery, Tx 77356-0767
Local Tel. (936) 582-1140 / Fax (936) 448-1013



Call Us Toll Free!
1(800) 361-8734

Dear Physician ,

We will submit your completed Physician's Professional Liability (Medical Malpractice) Insurance Application to several leading insurance carriers our agency represents that specialize in writing medical malpractice and/or medical professional liability insurance coverage. (See Application Pages 1 through 24 Below)

Most of these underwriters will accept initial applications submissions on other insurance carrier's application forms for review purposes or to issue an initial rate estimate. Final Rates and Acceptance with each insurance carrier presented by our agency is subject to each specific insurance companies application being fully completed & submitted to their underwriting staff for their review and final approval; this may be required before any coverage binder or policy may be issued.

Physician's Medical Malpractice Liability Insurance Companies We Offer

Insurance Company Name

ACE (USA and Bermuda)
American Reinsurance
Berkshire Hathaway
Certain Underwriters at Lloyds
Evanston (Markel/Shand)
General Star
Hudson

Insurance Company Name

Lloyds of London (and all syndicates)
Medical Protective
National Fire and Marine
ProAssurance
Red Mountain
RSUI (Landmark)

Please fully complete MS Word.Doc Fillable Application for submission to our Agency commercial lines underwriters.

Send To - **Email: edhemphill@hemphillinsuranceagency.com** or **Fax: (936) 448-1013**

[Physician's Click Here To Get Quick Online Med/Mal Price Indication](#)



Call Us Toll Free!
1(800) 361-8734

Edwin (Ed) L. Hemphill, C.I.C.
"Independent Insurance Agent"

Email: edhemphill@hemphillinsuranceagency.com

Website: <http://www.TheIndependentInsuranceAgency.com>