



**PROFESSIONAL UNDERWRITERS  
LIABILITY INSURANCE COMPANY**

A TDC Company

1888 Century Park East, Suite 850 Los Angeles, CA 90067-1737

**LOCUM TENENS APPLICATION**

**Instructions: All questions must be answered. Please type or print clearly. Upon approval, coverage for the Locum Tenens will be provided based on the specialty indicated on the Declarations and subject to the terms of the Policy and Endorsements. Limits of Coverage will be shared with the Named Insured.**

**NOTICE**  
This is an application for  
Locum Tenens Coverage  
under a CLAIMS-MADE  
POLICY

1. (a) Applicant's Full Name: \_\_\_\_\_ Degree/Title: \_\_\_\_\_  
 Other Name Used: \_\_\_\_\_ Birth Date: \_\_\_\_\_

(b) Social Security #: \_\_\_\_\_ (c) Federal DEA #: \_\_\_\_\_ Male  Female

(d) Home Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Number Street City County State Zip

(e) Principal Office: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Number Street City County State Zip Fax: (\_\_\_\_) \_\_\_\_\_

2. (a) Name of healthcare provider you are covering for: \_\_\_\_\_

(b) Requested Dates of Coverage: \_\_\_\_\_

3. Specify States where you are licensed:

_____ <small>(License #) (State of Licensure) (Field)</small>	_____ <small>(License #) (State of Licensure) (Field)</small>	_____ <small>(License #) (State of Licensure) (Field)</small>
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4. (a) Medical Specialty: \_\_\_\_\_ (b) Sub-Specialty: \_\_\_\_\_ % of Practice: \_\_\_\_\_

5. (a) Are you American Board Certified in your Specialty?  YES  NO Date(s) Certified: \_\_\_\_\_

(b) Are you American Board Certified in your Sub-Specialty?  YES  NO Date(s) Certified: \_\_\_\_\_

(c) Name(s) of Specialty Board(s): \_\_\_\_\_

(d) If you are a foreign medical graduate, are you certified by the Educational Commission for Foreign Medical Graduates?  YES  NO

(e) Have you ever failed any Board Certification testing?  YES  NO

If YES, please explain: \_\_\_\_\_

6. List all locations where you have practiced in the last 10 years:

	<u>Group Name</u>	<u>Street</u>	<u>City</u>	<u>County</u>	<u>State</u>	<u>During Years</u>
(a)	_____	_____	_____	_____	_____	_____
(b)	_____	_____	_____	_____	_____	_____
(c)	_____	_____	_____	_____	_____	_____
(d)	_____	_____	_____	_____	_____	_____

## ATTESTATION QUESTIONS

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 7. <b>If the answer to any of the following is YES, please give full details (including dates) on a separate sheet of paper:</b>   |                          |                          |
| (a) Have you <u>ever</u> had professional liability insurance declined, canceled, issued on special terms or non-renewed?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Have you <u>ever</u> been investigated or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency?<br><b>(If YES, provide copies of all Accusations, Decisions, Consent Orders, etc.)</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Has or is your license to practice medicine or your permit to prescribe or dispense drugs <u>ever</u> been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Have you <u>ever</u> had privileges at any hospital or other institution denied, reduced, revoked, restricted, or suspended?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Are you currently or have you <u>ever</u> been evaluated, treated or hospitalized for alcohol or drug abuse or a mental or emotional disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Have you <u>ever</u> been convicted of, or are you under indictment for, a felony?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Has your membership in any professional society or association <u>ever</u> been refused, censured, suspended or revoked?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Do you currently have or have you <u>ever</u> had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Are you currently or have you <u>ever</u> used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Has any physician, patient or insurance plan <u>ever</u> filed a complaint against you with any Medical Association/ Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Have you <u>ever</u> been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Have you <u>ever</u> been involved in a malpractice claim, suit or medical incident, either directly or indirectly, or are you presently involved in malpractice litigation? <b>(If YES, please complete a Claims Information Form for each.)</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Are you aware of any facts, circumstances, medical incidents, records requests or letters of intent that may give rise to a claim or suit? <b>(If YES, please complete a Claims Information Form for each, attached to this Application).</b>  | <input type="checkbox"/> | <input type="checkbox"/> |

## TRAINING & INSURANCE HISTORY

- |        |  |  |                            |
|--------|--|--|----------------------------|
| 8. (a) | Medical Degree from (school): _____  |  | Dates: _____               |
|        | City                      State                      Country                               |  | mm/dd/yy    to    mm/dd/yy |
| (b)    | Internship: _____  |  | Dates: _____               |
|        | Hospital                      City                      State                      Country |  | mm/dd/yy    to    mm/dd/yy |
| (c)    | Residency: _____   |  | Dates: _____               |
|        | Hospital                      City                      State                      Country |  | mm/dd/yy    to    mm/dd/yy |
| (d)    | Type of Residency: _____   |  |                            |
| (e)    | Residency: _____   |  | Dates: _____               |
|        | Hospital                      City                      State                      Country |  | mm/dd/yy    to    mm/dd/yy |
| (f)    | Type of Residency: _____   |  |                            |
| (g)    | Fellowship Training: _____   |  | Dates: _____               |
|        | Hospital                      City                      State                      Country |  | mm/dd/yy    to    mm/dd/yy |
| (h)    | Type of Fellowship: _____  |  |                            |

9. List any additional medical specialty training:

<u>Location</u>	<u>Type</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____



## NO KNOWN CLAIMS DECLARATION

I declare that I am not aware of, nor do I, or any agent, employee, representative, or any other person(s) serving or acting on my behalf have any knowledge of any claim, notice of claim, records request, letter of intent, incident, any unreported conduct, or any circumstance or occurrence which could reasonably be expected to result in a claim against me subsequent to the date of my signature below that I have not already reported to my previous professional liability carrier and which I have not disclosed on my application to Professional Underwriters Liability Insurance Company.

I have reported all claims, and all facts or circumstances that could give rise to a claim to appropriate prior carrier(s) and understand that all such known claims or potential claims will not be covered by this insurance. I also understand that this insurance does not apply to any of the following:

1. Any incident or claim for which I have received notice of a claim.
2. Any incident or claim for which a legal action has been filed against my employees or me.
3. Any incident or claim upon which any companies previously insuring me have previously established a claim file.
4. Any incident or claim arising out of any fact, circumstance, or situation indicating the possibility of a claim which was known to me as of the effective date of insurance for which I am applying.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Print Name

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## WARRANTY & RELEASE

I do hereby warrant the truth of all statements and answers mentioned herein, and that I have not withheld any information which may influence or would influence the judgment of the Company in considering this application for professional liability insurance.

I understand that if the information in this application materially changes between the date of this application and the policy effective date, I will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

I understand and agree that erroneous and/or material misrepresentations or omissions will cause immediate rescission of my insurance coverage.

I understand and agree that the Company will not provide defense or indemnity coverage for any claims, civil lawsuits, arbitration, legal or administrative proceedings, incidents, accidents, or events in which damages or liability is assumed or imposed, or sought to be imposed, upon an insured under a written or oral agreement, specifically including a "hold harmless" indemnification or similar agreement, where the damages or liability assumed by, imposed or sought to be imposed are greater than that which would exist in the absence of such an agreement.

This application form, duly completed, together with any supplementary information, **must** be signed and dated in ink by the applicant. Signature of the form does not bind the applicant or the Company to issue coverage.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, preceptorship, residency program, insurance company, underwriter and insurance agent/broker to furnish any information concerning me or my medical practice which the company or its representative may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction, together with the agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even if the information is wrong.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# CLAIMS INFORMATION FORM

## CLAIM INFORMATION - Please type or print clearly

1. Name of Patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_ 3. Sex: \_\_\_\_\_
4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon): \_\_\_\_\_  
\_\_\_\_\_
5. Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Date of Incident: \_\_\_\_\_ 7. Date Reported to Carrier: \_\_\_\_\_ 8. Location: \_\_\_\_\_
9. Insurance Carrier(s): \_\_\_\_\_
10. Other Defendants: \_\_\_\_\_
11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES  NO
12. Present Status: \_\_\_\_\_ Incident Only \_\_\_\_\_ Pending Suit \_\_\_\_\_ Closed  
Date Closed: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Settlement or Judgment (circle one)
13. Condition and diagnosis at time of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. Defense Counsel: \_\_\_\_\_
17. Plaintiff's Counsel: \_\_\_\_\_

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CLAIMS INFORMATION FORM**  
**(Please make additional copies if needed)**

**CLAIM INFORMATION - Please type or print clearly**

1. Name of Patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_ 3. Sex: \_\_\_\_\_
4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon): \_\_\_\_\_  
\_\_\_\_\_
5. Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Date of Incident: \_\_\_\_\_ 7. Date Reported to Carrier: \_\_\_\_\_ 8. Location: \_\_\_\_\_
9. Insurance Carrier(s): \_\_\_\_\_
10. Other Defendants: \_\_\_\_\_
11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES  NO
12. Present Status: \_\_\_\_\_ Incident Only \_\_\_\_\_ Pending Suit \_\_\_\_\_ Closed  
Date Closed: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Settlement or Judgment (circle one)
13. Condition and diagnosis at time of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. Defense Counsel: \_\_\_\_\_
17. Plaintiff's Counsel: \_\_\_\_\_

**I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## NOTICE:

The underwriter is authorized to make any inquiry in connection with this application. The underwriter's acceptance of this application or the making of any subsequent inquiry does not bind the applicant or the underwriter to complete the insurance or issue a policy.

If the information in this application materially changes between the date of this application and the policy effective date, the applicant will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

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**Colorado Applicants:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia Applicants:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Applicants:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky Applicants:** 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 commits a fraudulent insurance act, which is a crime.

**Louisiana Applicants:** 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 for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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

**Missouri Applicants:** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

**New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New Mexico Applicants:** 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 for insurance is guilty of a crime and may be subject to fines civil and criminal penalties.

**Ohio Applicants:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Applicants:** 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 any false, incomplete or misleading information is guilty of a felony.

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

**Rhode Island Applicants:** 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 for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Virginia Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

**West Virginia Applicants:** 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 for insurance is guilty of a crime and may be subject to fines and confinement in prison.