Baxter & Associates, LLC
HEALTHCARE PROFESSIONAL LIABILITY
DBA Baxter & Associates Insurance Services, LLC in CA, TX, and OK

MAIL - 4400 Bayou Blvd, Suite 52-B – Pensacola, FL 32503
PHONE – (800)641-8865 / (850)471-2993
FAX – (888)287-8894 / (850)471-2953
EMAIL – info@Baxter-Insurance.com

MD / DO APPLICATION for Medical Professional Liability / Malpractice Insurance

Name	Phone
Mailing Address	Fax
City, State, Zip	E-mail

Date of Birth	Social Security No
License Number/Date	Narcotics DEA Number

Medical Specialty	Sub-Specialty
Are you board certified? ☐Yes ☐No	If not board certified, are you board eligible? ☐Yes ☐No ☐n/a

Medical School	Date Graduated
Served Residency at	Completion date
Served Internship at	Completion date
Served Fellowship at	Completion date

List all counties in which you practice:	Which best describes your practice? ☐Individual (solo practice) ☐Employee ☐Independent contractor ☐Partner/shareholder*** ***Is corporation coverage desired? ☐Yes ☐No
Average number of patients per week:	
Average weekly number of hours practiced per week:	

Your current insurer - ☐ No current coverage	Current Malpractice Ins Premium-

Question	Answer
If you attended a foreign medical school, are you certified by the Educational Council for Foreign Medical Graduates?	☐Yes ☐No ☐n/a
Do you engage in any "moonlighting" activity?	☐Yes ☐No
Do you work in an emergency room?	☐Yes ☐No
Do you utilize a hospitalist for admissions?	☐Yes ☐No
Do you provide services at nursing homes?	☐Yes ☐No
If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer?	☐Yes ☐No ☐n/a
Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rending of or failure to render professional services which may give rise to a claim?	☐Yes ☐No
If yes, has this incident (these incidents) been reported to a prior insurer?	☐Yes ☐No ☐n/a
Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or had renewal refused?	☐Yes ☐No
Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society?	☐Yes ☐No
Have you ever voluntarily surrendered a license to practice medicine?	☐Yes ☐No
Has any state ever refused you a license to practice medicine or restricted, suspended or revoked your license to practice medicine?	☐Yes ☐No
Have you ever been investigated by any governmental agency?	☐Yes ☐No
Has any hospital ever denied, restricted, reduced, or suspended your privileges or invoked probation?	☐Yes ☐No
Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise?	☐Yes ☐No
Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or mental illness?	☐Yes ☐No
Have you ever been investigated for or had any sexual misconduct or battery allegations filed against you?	☐Yes ☐No
Have you ever been convicted or are you currently under investigation for a crime other than a traffic offense?	☐Yes ☐No
Have you ever been refused board certification?	☐Yes ☐No
Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged?	☐Yes ☐No

QUESTIONS? Call 1(800)641-8865

Please indicate below your best estimate of the ***number*** of the following procedures you expect to perform, or in which you will participate, in the next year, beginning with the date of your requested coverage:

Abortions - first trimester(↓)
☐ (Hospital)
☐ (Clinic)
☐ (Office)

Abortions - after first trimester (↓)
☐ (Hospital)
☐ (Clinic)
☐ (Office)

☐ Acupuncture
☐ Adenoidectomies

Anesthesia - obstetrical: (↓)
☐ (General)
☐ (Spinal)
☐ (Epidural)

Anesthesia - non-obstetrical (↓)
☐ (General)
☐ (Spinal)
☐ (Epidural)

☐ Anesthesia (other) -
☐ Angiographies
☐ Angioplasty
☐ Arteriorgraphies
☐ "Alternative" or "complementary" medicine procedures (as viewed by Most physicians) Please describe:

Assisting in major surgery (↓)
☐ (own patients)
☐ (other than own patients)

☐ Breast implants
☐ Breast reductions

Catheterizations: (↓)
☐ (Cardiac)
☐ (Arterial)
☐ (Other) –

☐ Chelation therapy
☐ Chemabrasion
☐ Chemical Peels
☐ Chemotherapy
☐ Colonoscopies
☐ Cosmetic implantation or injection of silicone or other materials - Please describe
☐ Cryosurgery - Please describe:
☐ D & C's

Deliveries(↓)
☐ (Vaginal)
☐ (Cesarean)
☐ (Vaginal after Cesarean)

☐ Discogram
☐ Electromyography
☐ Eyeliner pigmentation

☐ Endoscopies (other than proctoscopy/sigmoidoscopy Please describe:
☐ Fracture reductions- closed
☐ Fracture reductions - open
☐ Hair transplants, or other hair growing or replacement techniques

Hemorrhoidectomies: (↓)
☐ (Internal)
☐ (External)

☐ Herniorrhaphies

Laparoscopy: (↓)
☐ (Diagnostic)-Please describe
☐ (Surgical) - Please describe:

☐ Laser Surgery - indicate type of surgery:
☐ Liposuction
☐ Lumbar punctures
☐ Manipulation therapy
☐ Myelography
☐ Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts -Please indicate type of surgery

☐ Needle aspirations
☐ Needle biopsies
☐ Pacemaker insertion
☐ Pain management - Please indicate type:
☐ Pre-natal care
☐ Radial keratotomies
☐ Radiation - diagnostic
☐ Radiation - therapeutic
☐ Sclerotherapy (choose one) ☐<1mm ☐>1mm
☐ Shock therapy
☐ Spinal Surgery
☐ Tattoo removal
☐ Thoracentesis
☐ Tonsillectomies
☐ Total joint replacements
☐ Tubal ligations
☐ Vasectomies
☐ Venography
☐ Weight control by means other than diet or exercise – Please describe:
☐ Any other procedure you reasonably believe will be of interest to a medical liability insurer - Please describe:

Please indicate the ***percentage*** of your surgical practice, if any, that involves the following types of major surgery:

☐ Abdominal
☐ Bariatric
☐ Cardiac
☐ Colon/rectal
☐ General
☐ Gynecologic
☐ Hand
☐ Head and Neck
☐ Neurosurgical
☐ Obstetrical
☐ Opthamalogical
☐ Orthopedic - including spinal surgery
☐ Orthopedic - without spinal surgery
☐ Plastic – cosmetic
☐ Plastic – reconstructive
☐ Thoracic
☐ Traumatic
☐ Urologic
☐ Vascular

Requested effective date (12:01 A.M.):

Requested retroactive date (12:01 A.M.):

Requested limits of insurance
☐$200,000/$600,000 ☐$500,000/$1,500,000
☐$250,000/$750,000 ☐$1,000,000/$3,000,000
Other______________________________

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement or a claim or any false, incomplete or misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

APPLICANT'S REPRESENTATIONS AND AUTHORIZATION

I understand that no coverage will be bound until after the carrier has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of the carrier intent to provide coverage. If coverage is declined by the carrier, any advance payment will be promptly returned.
The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I authorize the release of any underwriting and/or claim information from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals, to the carrier and its subsidiaries or agents. I authorize to release certificates of insurance and claim information to any third party payor, HMO, PPO, hospital or Managed Care Organization.

____ Signature

______________________________ Date

Please also send: 1) Your current malpractice insurance policy declarations page, 2) Your CV, 3) Information on any claims.
FAX this application to (888)287-8894 **EMAIL** this application to info@Baxter-Insurance.com