

# Roush Insurance Services, Inc.

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- Deerfield Insurance Company
- Evanston Insurance Company
- Essex Insurance Company
- Markel American Insurance Company
- Markel Insurance Company
- Associated International Insurance Company

## PODIATRISTS PROFESSIONAL LIABILITY INSURANCE (Claims Made Basis)

### APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. If you have Curriculum Vitae (C.V.), please attach to application and check here [ ].
4. Please do not complete application earlier than 45 days before proposed effective of coverage.
5. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.  
(PLEASE TYPE OR PRINT IN INK)

### 1. APPLICANT INFORMATION

- a. (i) Full Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(ii) Home Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_
- b. (i) Principal business premise address: \_\_\_\_\_  
(Street) (County)  
\_\_\_\_\_  
(City) (State) (Zip)  
Phone: ( ) \_\_\_\_\_
- (ii) Other Offices: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
\_\_\_\_\_ Phone: ( ) \_\_\_\_\_
- c. Limits of Liability desired:  100,000/300,000  250,000/750,000  500,000/1,500,000  1,000,000/3,000,000
- d. Federal DEA Number: \_\_\_\_\_
- e. Your practice is: [ ] Solo Practitioner (unincorporated) [ ] Solo Practitioner (incorporated) [ ] Partnership  
[ ] Member of a group corp. [ ] Other (describe \_\_\_\_\_)
- f. If your practice is a partnership, group corporation, or association, or employ any physicians, please complete the following:  
(i) Please list the names of ALL other partners, stockholders, associates and employed physicians; and indicate the status of each:  
(a) \_\_\_\_\_ (d) \_\_\_\_\_  
(b) \_\_\_\_\_ (e) \_\_\_\_\_  
(c) \_\_\_\_\_ (f) \_\_\_\_\_
- g. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No  
If Yes,  
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No  
(ii) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_
- Our Business Associate Agreement is available at <https://www.markelcorp.com/en/US-Insurance/HIPAA>. This is the only Business Associate Agreement we will recognize.

### 2. PRACTICE

- a. Please list all states where you are licensed to practice:  
State: \_\_\_\_\_ License Number: \_\_\_\_\_  
State: \_\_\_\_\_ License Number: \_\_\_\_\_  
State: \_\_\_\_\_ License Number: \_\_\_\_\_

- b. Do you practice:  Full-time  Part-time \_\_\_\_\_ hours per week
- c. Please list all locations where you have practiced in the last ten years:  
 Name of Facility: \_\_\_\_\_ Address: \_\_\_\_\_ Year(s): \_\_\_\_\_  
 Name of Facility: \_\_\_\_\_ Address: \_\_\_\_\_ Year(s): \_\_\_\_\_  
 Name of Facility: \_\_\_\_\_ Address: \_\_\_\_\_ Year(s): \_\_\_\_\_
- d. (i) Average patient load: \_\_\_\_\_ Pts. Weekly \_\_\_\_\_ Total pts. Annually  
 (ii) Please indicate the number of days you work per week: \_\_\_\_\_  
 (iii) Please indicate the number of practice hours per day: \_\_\_\_\_ per week: \_\_\_\_\_
- e. Please provide a list of all professional health care personnel employed by or under contract with you or your entity. (If insured, please furnish the name of the insurance carrier and the policy number.)

Name	Job Category	Professional Liability Insurance

- f. Please list hospitals/surgery centers at which you are currently a staff member and show % of work at each location. Also submit copies of staff privileges. (If you request a Certificate of Insurance to be sent, please circle the number of the hospital/surgery center.)
- |          |         |
|----------|---------|
| 1) _____ | _____ % |
| 2) _____ | _____ % |
| 3) _____ | _____ % |
| 4) _____ | _____ % |

- g. Are you affiliated in any capacity with any of the following:
- (i) Any healthcare facility having bed and board accommodations? .....  Yes  No
- (ii) Any clinic, foundation, blood bank or laboratory? .....  Yes  No
- (iii) Any health maintenance organization (HMO), preferred provider organization (PPO), individual physicians' association, and/or any pre-paid health plan, etc.? .....  Yes  No

**PLEASE PROVIDE THE FOLLOWING FOR ANY "YES" ANSWERS:**

- 1) Please give the full legal name and location of the facility as well as the department in which you serve: \_\_\_\_\_  
 \_\_\_\_\_
- 2) Does the above facility provide insurance coverage for this work? .....  Yes  No
- 3) Please indicate your affiliation:  
 \_\_\_\_\_ Owner (whole or part) \_\_\_\_\_ Committee Member  
 \_\_\_\_\_ Executive Officer (e.g., Board Member) \_\_\_\_\_ Director – Dept. of Ancillary Services  
 \_\_\_\_\_ Physician with teaching responsibilities \_\_\_\_\_ Administrator  
 \_\_\_\_\_ Other (please describe): \_\_\_\_\_
- 4) How are you compensated for your services?  Salary  Percentage  Fee for Service  
 Honorary or non-paid
- 5) What type of contractual agreement do you have?  Oral  Written
- 6) Please indicate the number of practice hours per day: \_\_\_\_\_ per week:

- h. Do you practice any of the following:
- Sports Medicine .....  Yes  No
- Minimal Incision Surgery .....  Yes  No
- Emergency Room work .....  Yes  No
- Laser Surgery .....  Yes  No
- (i) For what type of treatment do you use the laser? \_\_\_\_\_
- (ii) How many times per week do you perform laser surgery? \_\_\_\_\_
- (iii) Please indicate the type of training you received in laser surgery. Please check all that apply:  
 Seminar  Course  Hands On  Preceptorship  Other  
 Please specify the name(s) of program(s): \_\_\_\_\_

**3. PROCEDURES**

a. Please complete the following list of procedures performed, adding any others in the space provided below.

**Instructions:** In column 1, please check each procedure performed.  
 In column 2, please list the number of times the procedure has been performed within the past two years.  
 In column 3, please use "O" or "H" to indicate whether in an office or hospital.  
 In column 4, please indicate the number of office procedures that would be considered "minimal incision surgery."

Name of Procedure	1	2	3	4	Name of Procedure	1	2	3	4
Fulguration of verrucae	[ ]	_____	_____	_____	Osteotomies with fusion-digits- Metatarsal heads	[ ]	_____	_____	_____
Curettage of verrucae	[ ]	_____	_____	_____	Implants	[ ]	_____	_____	_____
Excision of verrucae	[ ]	_____	_____	_____	Aneurysm	[ ]	_____	_____	_____
Avulsion of toenail	[ ]	_____	_____	_____	Tendon transfer (digital)	[ ]	_____	_____	_____
Onychoplasty	[ ]	_____	_____	_____	Tendon transfer (other)	[ ]	_____	_____	_____
Onychotripsy	[ ]	_____	_____	_____	Tendo Achilles lengthening	[ ]	_____	_____	_____
Subungual exostosectomy	[ ]	_____	_____	_____	Repair of ruptured tendon	[ ]	_____	_____	_____
I & D of superficial abscess	[ ]	_____	_____	_____	Tenodesis	[ ]	_____	_____	_____
Plantar lesion - skin	[ ]	_____	_____	_____	Tendon transplant	[ ]	_____	_____	_____
Tendotomy - digital tendon (exterior flexor)	[ ]	_____	_____	_____	Capsulotomy - rear foot	[ ]	_____	_____	_____
Capsulotomy - forefoot	[ ]	_____	_____	_____	Repair of syndactylism	[ ]	_____	_____	_____
Arthroplasty	[ ]	_____	_____	_____	Repair of polydactylism	[ ]	_____	_____	_____
Phalangectomy	[ ]	_____	_____	_____	Amputation	[ ]	_____	_____	_____
Closed reduction (digital)	[ ]	_____	_____	_____	Panmetahead resection	[ ]	_____	_____	_____
Open reduction (digital)	[ ]	_____	_____	_____	Excision of metatarsal	[ ]	_____	_____	_____
Tendon Lengthening - digital	[ ]	_____	_____	_____	Excision of trigonum	[ ]	_____	_____	_____
Soft tissue tumors - rear foot	[ ]	_____	_____	_____	Excision of tarsal bone	[ ]	_____	_____	_____
Osteoclasia	[ ]	_____	_____	_____	Closed reduction - rear foot	[ ]	_____	_____	_____
Foreign bodies - forefoot	[ ]	_____	_____	_____	Open reduction - other	[ ]	_____	_____	_____
Excision of accessory ossicles	[ ]	_____	_____	_____	Metatarsal tarsal fusions (MP-MT joints)	[ ]	_____	_____	_____
Metahead resection (partial or complete)	[ ]	_____	_____	_____	Arthrodesis of tarsus	[ ]	_____	_____	_____
Excision of sesamoids (1st MP)	[ ]	_____	_____	_____	Skin graft	[ ]	_____	_____	_____
Resection of metatarsal exostosis	[ ]	_____	_____	_____	Repair of osteomyelitis	[ ]	_____	_____	_____
Closed reduction (metatarsal)	[ ]	_____	_____	_____	Bone cysts and tumors	[ ]	_____	_____	_____
Terminal Syme (lesser digitals)	[ ]	_____	_____	_____	Cavus foot correction	[ ]	_____	_____	_____
Excision of nevi	[ ]	_____	_____	_____	Flatfoot correction	[ ]	_____	_____	_____
Soft tissue tumors - forefoot	[ ]	_____	_____	_____	Metatarsal adductus correction	[ ]	_____	_____	_____
Terminal syme (hallux)	[ ]	_____	_____	_____	Reconstruction of anomaly	[ ]	_____	_____	_____
Hemangioma - excision of	[ ]	_____	_____	_____	Ankle Arthroscopy	[ ]	_____	_____	_____
Plastic repair of skin - rear foot	[ ]	_____	_____	_____	ORIF Ankle Fracture	[ ]	_____	_____	_____
Repair of ruptured ligament-forefoot	[ ]	_____	_____	_____	Tarsal tunnel decompression	[ ]	_____	_____	_____
Planter fasciotomy and heel spurs	[ ]	_____	_____	_____	Ankle Arthrodesis	[ ]	_____	_____	_____
Excision of plantar fibromatosis	[ ]	_____	_____	_____	A-O fixation	[ ]	_____	_____	_____
1st metahead resection (partial or complete)	[ ]	_____	_____	_____	Ankle Stabilization	[ ]	_____	_____	_____
Hallux valgus repair (1st MP only)	[ ]	_____	_____	_____	Perform surgery on ankle Joint and lower leg?	[ ]	_____	_____	_____
Partial resection of hypertrophied tarsal bone	[ ]	_____	_____	_____	Perform surgery on tendoachilles?	[ ]	_____	_____	_____
Heel spur resection	[ ]	_____	_____	_____	Do you provide post-operative care?	[ ]	_____	_____	_____
Digital Fusions IP joints	[ ]	_____	_____	_____	Do you provide routine foot care in patients of any age that satisfy Medicare high-Risk criteria?	[ ]	_____	_____	_____
Use of K Wire-staples-implants-wire for fixation	[ ]	_____	_____	_____	Other procedures performed:	[ ]	_____	_____	_____
Joint or other implants or prostheses made of materials capable of degradation, erosion, fragmentation, and/or the provocation of inflammatory tissue reactions?	[ ]	_____	_____	_____					

- b. Do you administer anesthesia
- (i) Intravenous? ..... [ ] Yes [ ] No
  - (ii) Local? ..... [ ] Yes [ ] No
  - (iii) Nitrous Oxide? ..... [ ] Yes [ ] No

(iv) Other (describe) \_\_\_\_\_

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**4. HISTORY**

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a. Attach a detailed explanation with dates for any "Yes" answers:

- (i) Have you ever been convicted of a felony? ..... [ ] Yes [ ] No
- (ii) Have you ever had professional liability insurance declined, canceled, issued on special terms or non-renewed?..... [ ] Yes [ ] No
- (iii) Have you ever been investigated by a State Board of Medical Examiners, Narcotics Board, or other licensing or governmental regulatory agency? ..... [ ] Yes [ ] No
- (iv) Has your membership in any professional society or association ever been refused, censured, suspended or revoked? ..... [ ] Yes [ ] No
- (v) Have you ever had privileges at a hospital or surgery center reduced, revoked, restricted or suspended? ..... [ ] Yes [ ] No
- (vi) Have you now or ever had any chronic disability or had an interruption of your practice due to disability? ..... [ ] Yes [ ] No
- (vii) Have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties? ..... [ ] Yes [ ] No
- (viii) Have you ever been involved in a drug or alcohol diversion or rehabilitation program? ..... [ ] Yes [ ] No
- (ix) Have you ever been suspended by any governmental health program (e.g., Medicare)? ..... [ ] Yes [ ] No

b. Please list malpractice coverage for the past ten years:

Name of Insurer	Dates Covered From - To	Open	Claims Closed	Total
1) _____	_____	_____	_____	_____
2) _____	_____	_____	_____	_____
3) _____	_____	_____	_____	_____
4) _____	_____	_____	_____	_____
5) _____	_____	_____	_____	_____

c. If prior professional liability insurance was on a claims made basis, please indicate the retroactive exclusion date of coverage \_\_\_\_\_

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**5. CLAIMS**

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- a. Has any physician, patient or insurance plan ever filed a complaint against you with any Medical Association/Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau? ..... [ ] Yes [ ] No  
If yes, please complete a Claims Information form for each case.
- b. Are you aware of any facts or circumstances which may give rise to a claim or suit?..... [ ] Yes [ ] No  
If yes, please complete a Claims Information form for each case.
- c. Have you ever been involved in a malpractice claim or suit, either directly or indirectly, or are you presently involved in malpractice litigation? ..... [ ] Yes [ ] No  
If yes, please complete a Claims Information form for each case.

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**6. COVERAGE**

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a. Non-surgical, Podiatry, Category 1 [ ] Yes [ ] No

Limitation Provision One - coverage DOES NOT APPLY (except in an emergency requiring immediate and unexpected intervention) to injury arising out of any professional service listed below:

- (i) The administration of anesthesia other than topical or by means of local infiltration;
- (ii) The reduction of any fracture;
- (iii) The use of lasers;

- (iv) The administration of nitrous oxide-oxygen inhalation analgesia. (v)Assisting in the performance of any podiatric surgical procedure; and
- (vi) The performance of any procedure involving the cutting or penetration of any tissue, except:
  1. Incision and/or drainage of sebaceous cysts, abscesses, or hematoma;
  2. Curettage of verrucae;
  3. Incision and removal of foreign body from the superficial or subcutaneous tissue;
  4. Debridement of infected skin, abrasions or keratotic lesions;
  5. Debridement, excision or avulsion of nail plate, excluding permanent removal except those procedures which involve the use of electrical or chemical cautery;
  6. Needle penetration of the skin and blood vessels;
  7. Treatment of burns except the local treatment of third degree burns;
  8. Closed manipulative reductions of fractures of metatarsals and phalanges.

b. Intermediate Surgery [ ] Yes [ ] No

Limitation Provision Two - Coverage DOES NOT APPLY (except in an emergency requiring immediate and unexpected intervention) to injury arising out of any professional service listed below:

- (i) Treatment or reduction of compound fractures of the calcaneus or talus;
- (ii) Triple arthrodesis;
- (iii) Surgical procedures of the ankle joint which includes those parts of the tibia, fibula, the malleoli and their related structures;
- (iv) Surgical treatment of the muscles and tendons at the level of the ankle joint and in the leg involving arthroplasty, osteotomy, grafts, implants and arthrodesis; and
- (v) The administration of general anesthesia.

Coverage DOES APPLY to injury arising out of any professional services covered in Limitation Provision One:

1. All podiatric surgical procedures performed on the human foot except those excluded above; and
2. Assisting in the performance of any podiatric surgical procedure.

c. Advanced Surgery [ ] Yes [ ] No

Limitation Provision Three - Coverage DOES NOT APPLY (except in an emergency requiring immediate and unexpected intervention) to injury arising out of any professional service listed below:

- (i) The administration of general anesthesia.

Coverage DOES APPLY to injury arising out of all podiatric surgical procedures performed on the human foot and all of the services covered in Limitation Provisions One and Two.

- d. (i) Do you perform surgery in your office?..... [ ] Yes [ ] No
- (ii) Do you perform surgery in a hospital?..... [ ] Yes [ ] No
- (iii) Do you perform surgery in any other non-hospital facility?..... [ ] Yes [ ] No
- (iv) Do you only perform non-surgical procedures or minor surgical procedures that are within the subcutaneous tissue only and that do not require sutures? ..... [ ] Yes [ ] No
- (v) Do you assist in surgical procedures outside the scope of podiatric medicine?..... [ ] Yes [ ] No (If Yes, please explain.)
- (vi) Do you have a certificate to perform ankle surgery? (If Yes, please attach copy.)..... [ ] Yes [ ] No

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**7. PROFESSIONAL ORGANIZATIONS**

American Podiatric Medical Association	APMA	[ ] Yes [ ] No
American College of Foot Surgeons	ACFS	[ ] Yes [ ] No
Academy of Ambulatory Foot Surgeons	AAFS	[ ] Yes [ ] No

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**8. EDUCATION**

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a. List all the colleges and professional schools you attended:

<u>Name</u>	<u>Yrs. Attended</u>	<u>Date of Grad.</u>	<u>Degree</u>
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b. Post graduate education:

(i) Internship: [ ] Yes [ ] No

Hospital: \_\_\_\_\_

Location: \_\_\_\_\_  
(City) (State) (County)

Dates of Training: \_\_\_\_\_

(ii) Residency/Fellowship/Preceptorship: [ ] Yes [ ] No

Hospital: \_\_\_\_\_

Location: \_\_\_\_\_  
(City) (State) (County)

Dates of Training: \_\_\_\_\_

(iii) Additional medical/specialty training:

<u>Type of Training</u>	<u>Dates</u>
_____	_____
_____	_____

c. Board Certification: [ ] Yes [ ] No

If Yes, please indicate the name of the Board and the year certified: \_\_\_\_\_

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**9. ADDITIONAL INFORMATION**

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a. Please attach three (3) of your most recent advertisements.

b. Please enclose copies of all your ads (e.g., Yellow Pages, etc.)

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title (Officer, partner, etc.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.