



P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • [sales@tmlt.org](mailto:sales@tmlt.org)

## ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION IN THE MOONLIGHTING PROGRAM

**Thank you for choosing to apply with TMLT.** We know that you have choices when purchasing liability insurance to protect your reputation and your medical practice. We appreciate the opportunity to earn your business.

**A few items that are especially helpful to know at the start of the application process:**

### **Completing and submitting your application:**

- You must be a member of the Texas Medical Association or have a membership application pending to obtain coverage through TMLT. To start this process, please visit the TMA web site [www.texmed.org](http://www.texmed.org) or call 1-800-880-1300.
- Remember to sign and date your application once it is complete.
- Please review and sign the *Business Associate Agreement*.
- **Completion of one year of residency training (internship) is required prior to making an application.**
- Only claims-made coverage is available through the Moonlighting Program.

Our website has a wealth of information on products and services we offer, including Coverage types, Risk Management, Claims, and information about TMLT. Be sure and check out our FAQs.

**We want to make your application experience as simple as possible.** If you have any questions during the process, we will be happy to assist you. Call 1-800-580-8658 and ask for Sales and Business Development.

### **Payment Options**

Consider which billing and payment options are right for you. Billing can be invoiced monthly or quarterly as a recurring automatic draft using your Visa, MasterCard, American Express credit cards or by bank draft. If no billing option is chosen, you will be invoiced quarterly. Please visit [www.tmlt.org](http://www.tmlt.org) to select and set up your payment option or call Customer Service at 1-800-580-8658 ext. 5050 for assistance.



TEXAS MEDICAL LIABILITY TRUST

P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmlt.org

INDIVIDUAL APPLICATION FOR RESIDENTS/FELLOWS
PROFESSIONAL LIABILITY CLAIMS-MADE COVERAGE - MOONLIGHTING PROGRAM

POLICY NUMBER \_\_\_\_\_

(For Trust Use Only)

PLEASE TYPE OR PRINT IN BLACK INK. ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

1. \_\_\_\_\_ M.D. [ ] D.O. [ ]
First Name Middle Name Last Name

2. \_\_\_\_\_
Mailing address Street City State Zip Code

3. \_\_\_\_\_
Home address Street City State Zip Code

4. \_\_\_\_\_ # \_\_\_\_\_ # \_\_\_\_\_
Date of Birth Texas Medical License/Status Social Security Number

5. \_\_\_\_\_
Office Phone: Area Code Number Home Phone: Area Code Number Fax: Area Code Number

6. \_\_\_\_\_
Pager: Area Code Number Cell Phone: Area Code Number Email Address

7. Applicant is [ ] Resident [ ] Fellow pursuing training in the specialty of: \_\_\_\_\_

8. Date of anticipated completion of Residency or Fellowship: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
Month Day Year

Completion of one year of residency training (internship) is required prior to making application.

9. Select the type of practice for which moonlighting coverage is requested (check all statements listed below which apply)

Obstetrical care or administering general anesthesia is not eligible.

Class A

- [ ] Primary Care
[ ] Physicals
[ ] Minor Emergency Center/ Walk-in Clinic

Class B

- [ ] Assisting in Surgery
[ ] Radiology or Pathology

Class C

- [ ] Emergency Room

Other

- [ ] \_\_\_\_\_

10. List location(s) where you will practice outside of training program.

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

11. Moonlighting coverage is for practice outside of the graduate training program of 30 hours or less per week.

Indicate number of hours per week you will practice outside of training program: \_\_\_\_\_

12. Medical Education/Background

	SCHOOL/HOSPITAL	CITY/STATE	FROM / TO	DEGREE/SPECIALTY
Medical School				
Internship				
Residency				
Fellowship				

13. Professional Liability Coverage limits of liability desired: (Limits indicated are per claim and all claims)

- \$100,000/\$300,000    
  \$200,000/\$600,000    
  \$500,000/\$1,000,000

14. Requested coverage effective date 12:01 a.m. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

In no event shall the effective date of the policy, if issued, be earlier than or more than 90 days from the date TMLT receives this application.  
 (For physicians entering practice for the first time immediately following residency training, military service, or an academic position this effective date is extended to 120 days.)

15. Are you a member of the Texas Medical Association?  Yes  No

If no, since this is a prerequisite for coverage, is your membership pending?  Yes  No

Name of County Medical Society and date of application \_\_\_\_\_

**If you answer yes to questions 16-27, please provide details on page 3.**

16. Have you ever been treated for alcoholism or substance abuse? Yes  No

If yes, provide details and a recent statement of insurability from your treating physician.

17. Have you now or ever had any chronic illness, mental illness or physical defect? Yes  No

If yes, provide details and a recent statement of insurability from your treating physician.

18. Has your medical license or permit to prescribe drugs ever been under investigation or voluntarily surrendered? Yes  No

19. Has your medical license or permit to prescribe drugs ever been denied, restricted, revoked, suspended, or cancelled? Yes  No

20. (a) Has any hospital or clinic ever denied, restricted, suspended, or revoked your privileges? Yes  No

(b) Are you currently under investigation? Yes  No

(c) Have you ever resigned from a hospital, clinic, or other facility during or following a medical staff investigation? Yes  No

21. Has your membership in any professional society or association ever been denied, cancelled, revoked, or censured? Yes  No

22. Have you ever been indicted, charged or convicted of a crime other than a minor traffic violation? Yes  No

23. Have any fee complaints or professional relations complaints ever been made against you with your medical association, hospital or licensing authority? Yes  No

24. Have Medicare/Medicaid or their authorities ever brought charges against you for alleged fraud or inappropriate fees? Yes  No

25. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? Yes  No

26. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled or non-renewed? Yes  No

If yes, please explain why, when and name of insurer(s).

27. Are you aware that your present insurer plans to restrict, surcharge, cancel or non-renew your coverage? Yes  No

28. How many professional liability claims have **ever** been brought against you?

This includes notice of intent to sue, written demand from a patient or lawsuit. # \_\_\_\_\_

Complete the information for all claims/suits on page 4.

## AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any policy is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding. **I understand any policy issued by TMLT will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMLT any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: Texas Medical Board; any other licensing agency; Texas Medical Association; any other state medical association or organization; any county medical society; any specialty medical society or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability and/or Premises Liability Coverage. I further authorize TMLT and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

**This application incorporates by reference the terms and conditions of TMLT's HIPAA-HITECH Business Associate Agreement (reviewable at [www.tmlt.org/appdocs](http://www.tmlt.org/appdocs)), copies of which will be provided to me upon request. By signing and accepting below, I consent to the terms and conditions of these documents and agreements.**

By submission of this application, or by acceptance of coverage from TMLT, I hereby release TMLT and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date Signed

### **THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE**

**Coverage will not be considered until this application is completed, signed and dated. Failure to provide complete information and/or attachments as requested will cause delay.**



Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of incident: \_\_\_\_\_  
Month / Day / Year

Location: \_\_\_\_\_ Hospital: \_\_\_\_\_  
City State

Insurance company defending your claim: \_\_\_\_\_ Date reported: \_\_\_\_\_  
Month / Day / Year

**ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Co-defendants: \_\_\_\_\_

Is the claim still pending?  Yes  No

Method of resolution

Settled  Dismissed (with prejudice)  Dismissed (without prejudice)  Judgment for defendant(s)  Judgment for plaintiff(s)

Mediation or arbitration Total amount paid to claimant on **your** behalf: \$ \_\_\_\_\_

Date of resolution: \_\_\_\_\_ Total amount paid to claimant for **all** defendants: \$ \_\_\_\_\_  
Month / Day / Year

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of incident: \_\_\_\_\_  
Month / Day / Year

Location: \_\_\_\_\_ Hospital: \_\_\_\_\_  
City State

Insurance company defending your claim: \_\_\_\_\_ Date reported: \_\_\_\_\_  
Month / Day / Year

**ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Co-defendants: \_\_\_\_\_

Is the claim still pending?  Yes  No

Method of resolution

Settled  Dismissed (with prejudice)  Dismissed (without prejudice)  Judgment for defendant(s)  Judgment for plaintiff(s)

Mediation or arbitration Total amount paid to claimant on **your** behalf: \$ \_\_\_\_\_

Date of resolution: \_\_\_\_\_ Total amount paid to claimant for **all** defendants: \$ \_\_\_\_\_  
Month / Day / Year