ENCLOSED IS THE FORM NECESSARY FOR SUBSTITUTE PHYSICIAN (LOCUM TENENS) COVERAGE

- ❑ **You must be a licensed physician in Texas.**
- ❑ Complete and sign the *Application for Coverage*.
- ❑ Complete the *Claim/Suit Information Addendum* if a professional liability claim or suit has **ever** been brought against you.
- ❑ Enclose a copy of your current *Curriculum Vitae*.
- ❑ Enclose a letter from the TMLT physician who requests coverage be added to his or her policy for substitute coverage and include the specific dates coverage will be needed.

Please allow 10 days for processing. If you have any questions, please call TMLT at 1-800-580-8658.

TMLT
Texas Medical Liability Trust

P.O. Box 160140 • Austin, TX 78716-0140
901 Mopac Expressway South • Barton Oaks Plaza V, Suite 500 • Austin, TX 78746
800-580-8658 • 512-425-5800 • fax: 512-425-5999 • www.tmlt.org

Rev 8/13

TMLT
Texas Medical Liability Trust

Policy Number (For Trust Use Only)

P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5999 • www.tmlt.org

INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE SUBSTITUTE PHYSICIAN (LOCUM TENENS)

All questions must be answered in detail.

I. GENERAL INFORMATION

A. _____ **M.D.** ❑ **D.O.** ❑

First Name | Middle Name | Last Name

Home Address | City | State | Zip Code

Date of Birth | Texas Medical License/Status # | Social Security Number #

Office Phone: Area Code + Number | Home Phone: Area Code + Number | Fax: Area Code + Number

Pager: Area Code + Number | Cell Phone: Area Code + Number | Email Address

B. Do you have current professional liability coverage? **Yes** ❑ **No** ❑
If yes, provide the following:

Name of Company | Policy Period | Limits of Liability | Claims-made or Occurrence

II. UNDERWRITING AND RATING INFORMATION

A. Medical Practice History

1. Are you American Board Certified? Yes ❑ No ❑

Name of Specialty Board | Date(s) Certified

2. If not certified, are you admissible to a Specialty Board examination? Yes ❑ No ❑

Name of Board | Exam Date

3. Have you ever failed to pass a Board exam? Yes ❑ No ❑

Name of Specialty Board | Which portion?/Date(s)

4. Are you certified? ACLS ❑ ATLS ❑ PALS ❑

5. Have you ever been denied a medical license or certification by a Specialty Board? Yes ❑ No ❑
If yes, please provide details on page 4.

II. UNDERWRITING AND RATING INFORMATION CONTINUED

B. Medical Practice Description

1. What is your Medical Specialty? _____

If you answer yes to questions 2-16, please provide details on page 4.

2. Will you dispense or prescribe medications or use medical devices which are disapproved by the FDA in the treatment or care of human beings? Yes ❑ No ❑

3. 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.

4. Have you now or ever had any chronic illness, mental illness or physical impairment that affected or may affect your ability to practice medicine? Yes ❑ No ❑
If yes, provide details and a recent statement of insurability from your treating physician.

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

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

7. (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 ❑

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

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

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

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

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

13. 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).

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

15. Have you received any oral or written threats of legal action, attorney's request for patient records, subpoena, petition, complaint, summons, citation or other legal process or notification? Yes ❑ No ❑

16. 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 pages 4.

III. ADDITIONAL INFORMATION

Please use this area if additional space is needed for answers to questions.

Page Number	Question Number	Answer and/or Detail

IV. CLAIM/SUIT INFORMATION ADDENDUM

If additional space is required, please photocopy this form as needed.
Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.

1. CLAIM/SUIT INFORMATION

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

Insurance company defending your claim: _____

Location: City_____ State _____ Hospital _____

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:_____

Claim is pending: Yes ❑ No ❑

Lawsuit filed: Yes ❑ No ❑ If Yes: Month_____ Year _____

Court Trial: Yes ❑ No ❑ Jury verdict: Yes ❑ No ❑

Settled without indemnity payment on your behalf? Yes ❑ No ❑

Settlement out of court: Yes ❑ No ❑ If Yes: Month_____ Year _____

Total amount paid to claimant on **your** behalf: $_____

Total amount paid to claimant for **all** defendants: $ _____

V. 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 coverage is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any coverage 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 Premise 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), 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 agreeements.

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/attachments as requested will cause delay.

ENCLOSE a copy of your current **Curriculum Vitae.**