TMLT
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

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** or call 1-800-880-1300.
- Remember to sign and date your application once it is complete.
- Please review 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 to select and set up your payment option or call Customer Service at 1-800-580-8658 ext. 5050 for assistance.

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TEXAS MEDICAL LIABILITY TRUST

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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	***Class B***	***Class C***	***Other***
☐ Primary Care	☐ Assisting in Surgery	☐ Emergency Room	☐ _____
☐ Physicals	☐ Radiology or Pathology		
☐ Minor Emergency Center/ Walk-in Clinic			

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: _____

Rev 06/2006

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 prescibe 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), 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.

ADDITIONAL DETAILS (Please use this area if additional space is needed for answers to any questions.)

PAGE NUMBER	QUESTION NUMBER	ANSWER AND/OR DETAILS

CLAIM/SUIT INFORMATION

If additional space is required, please photocopy this form as needed. PLEASE TYPE OR PRINT IN BLACK INK. Note: Additional documentation may be requested by the Underwriting Department.

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

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: _____

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