Wisconsin Health Care Liability Insurance Plan

☐ Initial ☐ Renewal

Application to the Wisconsin Health Care Liability Insurance Plan

The JMJ Agency LLC Phone: 704-905-3462 Fax: 704-951-8203

For Medical Professional Liability Insurance

This is an Application Only; it does not constitute an insurance policy. Insurance shall become effective only on issuance of a policy or a written binder specifically authorized by the Plan.

EVERY ITEM MUST BE COMPLETED. IF NOT APPLICABLE WRITE "NONE."

Return to: The JMJ Agency LLC
17145 J W. Bluemound Rd. #261
Brookfield, WI 53005

Telephone Number _____

1. (a) Full Name _____ Date of Birth _____

Former Name/Maiden Name _____

Professional Address _____

Send mail to: _____

Home Address _____

(b) I wish my insurance to become effective _____

(c) The year I started practice _____.

2. (a) My principal place of practice is in the State of Wisconsin? _____ ☐ Yes ☐ No

(b) Are you registered and licensed to practice your profession in the State of Wisconsin? _____ ☐ Yes ☐ No

(c) State of Wisconsin Professional License Number _____ Field of Licensure _____

(d) Other States you are licensed in:

STATE	LICENSE NUMBER	FIELD OF LICENSURE

(e) Social Security Number _____ **(optional)**

(f) Your Federal Drug Enforcement Administration number(s) _____
_____
_____

3. Name and location of all hospitals you are affiliated with:

NAME	LOCATION

4. Medical School(s):

NAME OF SCHOOL	LOCATION	DEGREE	YEAR OF GRADUATION

If foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?
☐ Yes Year _____ ☐ No

5. I hereby make application for coverage on the following basis:
☐ In Practice Physician or Surgeon
☐ Government – Employed Physician or Surgeon: **(Please also complete No. 12)**
☐ Coverage Limited to Government Employment ☐ Coverage Limited to Outside Medical Practice
☐ Retired Physician or Surgeon **(Please also complete No. 14)**
(This limited practice classification is applicable only to semi-retired physicians who practice less than 500 hours per year, limited their practice to office practice only and perform no surgical procedures.)
☐ Medical Director Coverage (Retired Physician or Surgeon classification will apply.) **Please also complete No. 15.**
(This coverage can be provided to a physician who spends the majority of their time in administrative work and practice less than 500 hours per year in the practice of medicine.
☐ Locum Tenens Coverage **(Please also complete No. 16)**
Coverage will be provided on a per day, or longer, basis.
☐ Physician pursuing training in an approved Post Graduate Medical Education Program: **(Please also complete No. 13)**
☐ Coverage limited to Post Gradate Medical Education Only ☐ Coverage Limited to outside medical practice only

6. My practice or medical specialty is: _____

Subspecialties _____

7. Name specialty board certifications, which you hold.

_____ Year _____

_____ Year _____

_____ Year _____

_____ Year _____

8. Do you perform any one or more of the following procedures?

(a) Catheterization – cardiac	☐ Yes	☐ No
(b) Radiation Therapy	☐ Yes	☐ No
(c) Electroconvulsive therapy	☐ Yes	☐ No
(d) Interventional Radiology	☐ Yes	☐ No

9. Do you perform any one or more of the following procedures?

(a.) Minor * surgery other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia	☐ Yes	☐ No
(b) Assisting in major* surgical procedures on your own patients	☐ Yes	☐ No
(c) Major* surgery	☐ Yes	☐ No
(d) Assisting in major* surgical procedures on other than your own patient	☐ Yes	☐ No
(e) Normal obstetrical procedures not considered to be major* surgery	☐ Yes	☐ No
(f) Obstetrical procedures which are considered to be major* surgery	☐ Yes	☐ No
(g) Plastic surgery – reconstructive	☐ Yes	☐ No
(h) Plastic surgery – cosmetic	☐ Yes	☐ No
(i) Weight control by means other than diet or exercise, including prescriptions	☐ Yes	☐ No
(j) Administer general, spinal, caudal anesthesia	☐ Yes	☐ No

*Tonsillectomies, Adenoidectomies and Cesarean Sections are considered to be major surgical procedures.

10. (a) Do you work in an emergency room? ☐ Yes ☐ No
If "yes," give number of hours a week _____ a year _____

(b) Do you work in an intensive care unit? ☐ Yes ☐ No
If "yes," give number of hours a week _____ a year _____

(c) Do you work in an urgent care center? ☐ Yes ☐ No
If "yes," give number of hours a week _____ a year _____

11. Are you in active U. S. Military Service? ☐ Yes ☐ No

12. Are you employed full time by Municipal, State or Federal Government (not active in U.S. Military Service?) ☐ Yes ☐ No

Name of Employer _____
(Answer questions 6, 8, 9, and 10 based on your Government Employment.)

13. Post Graduate Medical Education
If you are currently engaged in an approved post graduate medical education program, complete the following:

(a) Name of institution _____

(b) Indicate your level in the post graduate medical education program:
☐ Post Graduate I (Internship) ☐ Post Graduate II – VI (Residency) ☐ Fellow
Give specialty you are presently pursuing: _____
(Answer questions 6, 8, 9, and 10 based on your Training Program.)

(c) If you are making application for coverage only for medical practice engaged in outside or your training program, state number of hours engaged in outside medical practice per week _____ per year _____

(d) Date of anticipated completion of post graduate medical education: _____

14. Retired Physician or Surgeon. If you are making application for limited practice, complete the following:

Type of practice presently engaged in _____

Number of hours practicing per week _____ per year _____

15. Medical Director.
If you are making application for medical director coverage only, complete the following:

Number of hours **providing medical services** per week _____ per year _____

16. Locum Tenens.
Please provide the assignment: Start Date _____ and End Date _____
A new application is not required for each new assignment; however, a new application must be submitted annually.
Additional assignment dates can be submitted by letter or fax.
(Answer questions 6, 8, 9, and 10 based on your Locums Assignment.)

17. Are you the owner, a partner or stockholder in a medical partnership, corporation or cooperative? ☐ Yes ☐ No

If "yes," do you desire coverage for this entity? ☐ Yes ☐ No

If you answered "yes," to the above, please complete (a) and (b) below and request a separate application for the entity.

(a) State name and address of ☐ Partnership, ☐ Corporation, ☐ Co-operative or ☐ Solo Corporation

_____

(b) List all Partners or Stockholders

Name	Specialty	Insurer	Limits

18. if you answered "no" to number 17, do you individually have employees? ☐ Yes ☐ No

If "yes," is it your intent to provide coverage to you employees under your policy? ☐ Yes ☐ No

If you answered "yes," to the above, please respond to the following:

18. Do you employ any of the following?

Licensed Nurse Anesthetist?	☐ Yes	☐ No	If "yes," specify number
Surgical Podiatrists?	☐ Yes	☐ No	If "yes," specify number

NOTE: the plan offers individual policies for physicians and surgeons, nurse anesthetists, surgical and nonsurgical podiatrists, nurse midwives, cardiovascular perfusionists and nurse practitioners. Separate applications are available for each.

19. Do you employ any of the following allied health care personnel? ☐ Yes ☐ No

If "yes," complete the following:

Description	No. of Employees FTE	Are They Insured for Professional Liability?	Insurer and For What Limits of Liability
Physicians' Assistant or Surgeons' Assistant		☐ Yes ☐ No	
Nurse Practitioner		☐ Yes ☐ No	
Nurse – Licensed (RN or LPN))		☐ Yes ☐ No	
Additional Charge for X-Ray Therapy		☐ Yes ☐ No	
Technician - Radium, Laboratory or Pathological		☐ Yes ☐ No	
Technician – X-ray		☐ Yes ☐ No	
Additional Charge for X-Ray Therapy		☐ Yes ☐ No	
Cardiovascular Perfusionists		☐ Yes ☐ No	
Physiotherapist		☐ Yes ☐ No	
Chiropractor		☐ Yes ☐ No	
Oral Surgeon		☐ Yes ☐ No	
Optometrist		☐ Yes ☐ No	
Other Allied Health Care Personnel (List numbers by type)		☐ Yes ☐ No	
Description:		☐ Yes ☐ No	

I HEREBY CERTIFY THAT I AM A LICENSED INSURANCE AGENT OF WISCONSIN REGISTRATION NUMBER 2512957 EXPIRING April 30th 20 11. IN THE EVENT A POLICY IS ISSUED AND THEN CANCELED OR INSURANCE THEREUNDER TERMINATED, OR A CHANGE IS MADE RESULTING IN A RETURN PREMIUM DUE, I AGREE UPON REQUEST TO RETURN MY PROPORTIONATE SHARE OF THE COMMISSION ON SUCH RETURN PREMIUM.

Signature of Producer

Joseph M Jordan
Name of Producer (Type or Print)

Producer Social Security Number – IRS Tax Number

Telephone Number of Producer 704-905-3462

8006 Turnberry Lane Stanley NC 28164
Address of Producer

IMPORTANT: THIS APPLICATION AND RELEASE MUST BE SIGNED BY THE PHYSICIAN.

The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT

DATE OF SIGNATURE

I authorize release and exchange of information involving, but not limited to, claim matters between my professional society or association, prior insurance carrier, hospital and/or clinic, and the Wisconsin Health Care Liability Insurance Plan.

SIGNATURE OF APPLICANT

DATE OF SIGNATURE

SOME OF THE QUESTIONS ON THIS APPLICATION ARE TO PROVIDE INFORMATION FOR THE NATIONAL PRACTITIONER DATA BANK, WHICH IS MANDATED BY THE 1986 HEALTH CARE QUALITY IMPROVEMENT ACT.

Wisconsin Health Care Liability Insurance Plan

PROFESSIONAL LIABILITY PREMIUM SCHEDULE

EFFECTIVE JULY 1, 2009

Coverage A - Individual Professional Liability
Physicians - Surgeons - Osteopaths
(In Practice Rates)

	Limits 1,000/3,000
Class 1	$ 12,098
Class 2	18,148
Class 3	20,567
Class 4	25,407
Class 5	47,184
Class 6	52,024
Class 7	62,912
Class 8	6,050
Class 9	114,935

Coverage A - Individual Professional Liability
Physicians - Surgeons - Osteopaths Post Graduate Medical
(Education Rates)

	Limits 1,000/3,000
Class 1	$ 3,630
Class 2	5,445
Class 3	6,171
Class 4	7,623
Class 5	14,156
Class 6	15,609
Class 7	18,876
Class 9	34,484

Coverage A - Individual Professional Liability
Physicians - Surgeons - Osteopaths Government Employed
(Rates)

	Limits 400/1,000
Class 1	$ 6,756
Class 2	10,135
Class 3	11,486
Class 4	14,189
Class 5	26,351
Class 6	29,053
Class 7	35,134
Class 8	3,633
Class 9	64,187

Coverage B - Partnership - Corporation

The premium charge for a partnership/corporation policy when all of the partners or stockholders are individually insured by the Plan is a flat charge of $250 at policy limits, with this charge covering the liability for all partners, executive officers, directors, stockholders, and all employed physicians and surgeons.

The premium charge for a partnership/corporation policy when all of the partners or stockholders are not individually insured by the Plan is 5% of each partners' or shareholders' individual premium, based on Plan physicians and surgeons rate.

Additional Charges (Coverages A and B)

	Limits 1,000/3,000
Vicarious Liability - Employed Physicians or Surgeons Assistants	$ 91
Vicarious Liability - Employed Nurse Anesthetists	181
Vicarious Liability - Employed Chiropractors	302
Vicarious Liability - Employed Oral Surgeons	2,722
Vicarious Liability - Employed Optometrists	56
Vicarious Liability - Employed Surgical Podiatrists	2,056