



**2004  
Lifespan Malpractice Plan  
Application for Claims-Made, Healthcare-Provider Professional-Liability Coverage for  
RHODE ISLAND Medical Professionals**

**DIRECTIONS -- All Applicants**

Information provided by you in this Application will be used for purposes of underwriting and determining eligibility for claims-made, healthcare-provider, professional-liability (malpractice) coverage by the Lifespan Malpractice Plan.

- Throughout this Application: the Lifespan Malpractice Plan may be referred to as the “Plan”; the term “Coverage” refers to claims-made, healthcare-provider, professional-liability (malpractice) coverage; the term “Applicant” may apply to both initial applicants and renewal applicants; the term “Application” refers to this application document.
- Please complete the application by typing or printing *all* requested information by checking (“√”) the appropriate response or by providing information in the indicated spaces. Please attach additional pages should the space provided not be adequate.
- This application may be used for either initial applications or renewal applications. See the headings of each section designating either *all applicants* or *initial applicants*.
- *You must sign and date the application.* Incomplete applications may delay processing.
- Please retain a copy of this completed and signed application for your files.
- Forward completed applications to Lifespan Risk Services: 167 Point Street, Suite 1A, Rm 170, Providence, RI 02903, Fax: 401.444.8963.
- Should you have any questions, please call 401.444-2018.

**PERSONAL / PRACTICE INFORMATION -- All applicants**

**Full Name of Applicant:** \_\_\_\_\_

**Professional Designation:** ( ) MD, ( ) PhD, ( ) DO, ( ) Other: \_\_\_\_\_

**Medical Practice Organization**

- Name of Entity (if any): \_\_\_\_\_
- Type of Relationship that You have with this Entity (as defined by the Internal Revenue Service)--Select *one*:  
( ) Self employed; ( ) Direct employee; ( ) Contracted service; ( ) Other explain: \_\_\_\_\_
- Standard Hours of Your Relationship with this Entity--Select *one*:  
( ) 1.0 full-time equivalent (FTE); ( ) Less than 1.0 FTE -- Please indicate FTE: \_\_\_\_\_
- Month and Year that Your Relationship with this Entity began (e.g., date of employment): \_\_\_\_\_
- If less than 1.0 FTE with this Entity, indicate the following—Select one or more that apply:
  - ( ) No services provided outside Your Relationship with this Entity
  - ( ) Services provided for *other* organization(s):  
Name of organization: \_\_\_\_\_  
FTE: \_\_\_\_\_; Type of Relationship: \_\_\_\_\_

Current active professional-liability coverage/insurer concerning your services with that organization:

\_\_\_\_\_

- ( ) Services provided in your own private practice: Name of organization (if applicable): \_\_\_\_\_  
Name of current active professional-liability insurer: \_\_\_\_\_

### Primary Location of Your Practice

Street \_\_\_\_\_ Building/Suite Number \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### Coverage Period

Please indicate the period for which you are applying for Coverage through the Plan.

From (MM/DD/YY): \_\_\_\_\_ through (09/30/YY): \_\_\_\_\_

*References to the "Coverage Period" made throughout this application represent this indicated period.*

Note: The Plan provides coverage through the last day of Lifespan's fiscal year, which is September 30th.

Renewal of the Plan's coverage, to be effective on October 1st of the new fiscal year, would be required.

### Coverage Limits

Please indicate the *per medical-incident limit* that you desire: ( ) \$2M; ( ) \$1M.

Please note that eligibility criteria apply for certain coverage limits, and shared annual-aggregate limits apply.

### PROFESSIONAL PRACTICE DESCRIPTION:

#### PRIMARY SPECIALTY / SECONDARY SPECIALTY or SUB-SPECIALTY -- All Applicants

Please check ("√") the primary professional-practice specialty (and, if applicable, secondary or subspecialty) for which you are applying for coverage by the Plan during the Coverage Period.

**You must indicate at least one, primary, professional-practice specialty.**

- A professional practice (primary specialty, secondary specialty, or sub-specialty), procedure, or activity anticipated to be engaged/performed ***just once as an integral part*** of your professional practice during the Coverage Period would need to be checked.
- A professional practice (primary specialty, secondary specialty, or sub-specialty), procedure, or activity that may be ***incidentally*** engaged/performed (i.e., not anticipated to be an integral part of your professional practice) during the Coverage Period would not need to be checked.
- *For purposes of the Plan and this Application*, the following definitions apply. Please read them carefully. Descriptions of professional practices that indicate major or minor surgery within the description phrase would imply such activities. Descriptions of professional practices that do not indicate major or minor surgery in the description phrase would imply no major surgical or minor surgical activities.
- **Major Surgery:** Operations or supervising of operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis; or any operation which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life; or any operation using general anesthesia. The following would be considered examples of major surgery: removal of tumors, open bone fractures, amputations, the removal or repair of any gland or organ, plastic surgery, tonsillectomies, denoidectomies, and cesarean sections.
- **Minor Surgery:** All other invasive surgical procedures (i.e., surgically penetrating the body cavity and/or surgically penetrating beneath the epidermis, including sigmoidoscopy) not constituting major surgery, assisting in major surgery on your own patients, obstetrical procedures not constituting major surgery. **Note:**

For Medicine Specialties and Medicine Sub-Specialties, a medical-practice description that includes “minor surgery” would indicate a rate class that is greater than 1.

- **No Surgery:** No invasive surgical procedures as defined above. Procedures *intending to treat skin-related conditions*--that may be performed on the epidermis, and/or that may penetrate the epidermis, and/or that may penetrate beneath the epidermis--would not be considered to be surgical procedures. The following are examples of such skin-related-treatment procedures: incision or draining of boils and superficial abscesses, suturing of skin or superficial fascia.

### Major Surgery Specialties

Professional Practice Description	Code	Primary Specialty ("√")	Secondary or Sub- Specialty ("√")
Abdominal surgery	80166		
Cardiac surgery (Note: see below for cardiovascular disease surgery)	80141		
Cardiovascular disease surgery	80150		
Colon and rectal surgery	80115		
Endocrinology surgery	80103		
Family practice, GP – including all OB	80468		
Gastroenterology surgery	80104		
General surgery	80143		
Geriatrics surgery	80105		
Gynecology surgery	80167		
Hand surgery	80169		
Head & neck surgery	80170		
Laryngology surgery	80106		
Neoplastic surgery	80107		
Nephrology surgery	80108		
Neurology, including children’s surgery	80152		
Obstetrics, gynecology surgery	80153		
Obstetrics, surgery	80168		
Ophthalmology, surgery	80114		
Orthopedic, excluding spinal surgery	80354		
Orthopedic, including spinal surgery	80154		
Otolaryngology surgery	80142		
Otology, Major Surgery	80158		
Otorhinolaryngology surgery	80159		
Plastic – otorhinolaryn surgery	80155		
Plastic surgery	80156		
Rhinology surgery	80160		
Thoracic surgery	80144		
Traumatic surgery	80171		
Urology surgery	80145		
Vascular surgery	80146		

### Eye, Ear, Nose, Throat Specialties (With or Without Minor Surgery)

Professional Practice Description	Code	Primary Specialty ("√")	Secondary or Sub-Specialty ("√")
Laryngology, no surgery	80258		
Laryngology, minor surgery	80285		
Ophthalmology, no surgery	80263		

Ophthalmology, minor surgery	80289		
Otology, no surgery	80264		
Otology, minor surgery	80290		
Otorhinolaryngology	80265		
Otorhinolaryngology, minor surgery	80291		
Rhinology, no surgery	80247		
Rhinology, minor surgery	80270		

**Medicine Specialties (With or Without Minor Surgery)**

Professional Practice Description	Code	Primary Specialty ("√")	Secondary or Sub-Specialty ("√")
Allergy	80254		
Cardiovascular Disease, no surgery	80255		
Cardiovascular Disease, minor surgery	80281		
Diabetes, no surgery	80237		
Diabetes, minor surgery	80271		
Endocrinology, no surgery	80238		
Endocrinology, minor surgery	80272		
Gastroenterology, no surgery	80241		
Gastroenterology, minor surgery	80274		
General Preventative Medicine, no surgery	80231		
Geriatrics, no surgery	80243		
Geriatrics, minor surgery	80276		
Gynecology, no surgery	80244		
Gynecology, minor surgery	80277		
Hematology, no surgery	80245		
Hematology, minor surgery	80278		
Infectious Disease, no surgery	80246		
Infectious Disease, minor surgery	80279		
Intensive Care Medicine	80283		
Internal Medicine, no surgery	80257		
Internal Medicine, minor surgery	80284		
Neurology, including children, no surgery	80261		
Neurology, including children, minor surgery	80288		
Neoplastic disease, no surgery	80259		
Neoplastic disease, minor surgery	80286		
Nephrology, no surgery	80260		
Nephrology, minor surgery	80287		
Nuclear medicine	80262		
Nutrition	80248		
Occupational medicine	80233		
Pediatrics, no surgery	80267		
Pediatrics, minor surgery	80293		
Pharmacology, Clinical	80234		
Pulmonary disease, no surgery	80269		
Rheumatology, no surgery	80252		

**Physiatry/Orthopedic Specialties (With or Without Minor Surgery)**

Professional Practice Description	Code	Primary Specialty ("√")	Secondary or Sub-Specialty ("√")
Phys. (NOC), no surgery	80268		

Phys. – no major surgery, major invasive procedures	80422		
Phys. – no major surgery, minor invasive procedures	80443		
Phys. (NOC), minor surgery	80294		

**Emergency Medicine** (With or Without Minor Surgery and Surgery)

Professional Practice Description	Code	Primary Specialty ("√")	Secondary or Sub-Specialty ("√")
Emergency Medicine, no major surgery (board cert.)	80102		
Emergency Medicine, no major surgery (no board cert.)	80464		
Emergency Medicine, including major surgery (board cert.)	80157		
Emergency Medicine, including major surgery (no board cert.)	80465		

**Family Practice** (With or Without Minor Surgery and Surgery)

Professional Practice Description	Code	Primary Specialty ("√")	Secondary or Sub-Specialty ("√")
Family Practice, GP (excluding all OB), no surgery	80420		
Family Practice, GP – including prenatal only	80466		
Family Practice, GP – including vaginal delivery only	80467		
Family Practice, GP (excluding all OB), minor surgery	80421		
Family Practice, GP – including all OB	80468		
Family Practice, GP, surgery	80117		

**Other Specialties or Sub-Specialties** (With or Without Minor Surgery)

Professional Practice Description	Code	Primary Specialty ("√")	Secondary or Sub-Specialty ("√")
Aerospace Medicine	80230		
Anesthesiology	80151		
Bronchoesophagology	80101		
Dermatology, minor surgery	80282		
Dermatology, no surgery	80256		
Forensic medicine, Legal medicine	80240		
Hypnosis	80232		
Pathology, minor surgery	80292		
Pathology, no surgery	80266		
Psychiatry	80249		
Psychoanalysis	80250		
Psychosomatic medicine	80251		
Public Health	80236		
Radiology, Diagnosis, Including Coronary Arteriography	80280		
Radiology, Diagnosis (No Coronary Arteriography)	80253		
Retired	80221		
Volunteer	80220		

**For all Specialties or Sub-specialties**, please indicate any procedures that would not ordinarily be standard to the professional practice description(s) that you have selected:

**AFFILIATION AND PROFESSIONAL LICENSE -- All Applicants**

**Staff Privileges**

Do you have active staff privileges through any of the following Lifespan Partners' Medical Staff Associations?  
Please respond to each one listed.

Lifespan Partner	Active Privileges*	If Yes, Indicate Expiration Date**	Do You Intend to Renew / Apply?	Status of (renewal) Application / Explanation
Rhode Island Hospital	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No	
The Miriam Hospital	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No	
Emma Pendleton Bradley Hospital	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No	
Other:	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No	

\* If “no,” please indicate the status of your (renewal) application by completing the last two columns.

\*\* If you do not have staff privileges or if your staff privileges will expire during the Coverage Period, please complete the last two columns of this table.

Active staff privileges with an affiliated teaching hospital (i.e., a Lifespan hospital affiliated with a Brown University) are required in order to be eligible for the Plan’s coverage. Active staff privileges ranging from “courtesy” to “full” would be acceptable.

**Lifespan Physicians PSO**

Are you currently a member of, or are you applying for membership to, the Lifespan Physicians PSO via membership to any of the following Independent Practice Association (IPA)? Please respond to each one listed.

Lifespan Partner-affiliated IPA	Active Membership	If No to Active Membership-- Do You Intend to Apply?
Rhode Island Hospital IPA	( ) Yes; ( ) No	( ) Yes; ( ) No
The Miriam Hospital IPA	( ) Yes; ( ) No	( ) Yes; ( ) No
EP Bradley Hospital IPA	( ) Yes; ( ) No	( ) Yes; ( ) No
Other:	( ) Yes; ( ) No	( ) Yes; ( ) No

**Medical / Professional License Information**

Do you have an *active, full* medical or other requisite professional license relating to your professional practice?  
Please respond to each one listed.

Professional License Type	Issuing State	Active, Full Professional License*	If Yes, Indicate Expiration Date**	Do You Intend to Renew / Apply?	Status / Explanation
Medical Doctor (MD)	( ) RI; ( ) MA	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No--Explain>>	
Doctor of Osteopathy (DO)	( ) RI; ( ) MA	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No--Explain>>	
Psychologist (PhD)	( ) RI; ( ) MA	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No--Explain>>	
Other (specify):	( ) RI; ( ) MA	( ) Yes; ( ) No**; ( ) Not Applicable	/ /	( ) Yes; ( ) No--Explain>>	

\*An *active, full*, professional license for your indicated professional practice, which is legally requisite by of the state(s) in which you intend to practice, is required in order to be eligible for the Plan’s coverage.

\*\* If you do not have an active, full professional license, or if your license will expire within the Coverage Period, please complete the last two columns of this table.

**COVERAGE and CLAIMS EXPERIENCE -- *Initial* Applicants Only.**

**History of professional-liability coverage**

Please indicate the professional-liability coverage that you have or have had up to the point of applying for the Plan’s coverage. ***You must attach the “Declarations” page (a.k.a., “face sheet”) of the professional-liability insurance policy (or other relevant coverage document) currently in force or recently expired.***

Name of Indemnitor (e.g., Insurer) Providing Current or Prior Coverage	Dates of Coverage (MM/YY-MM/YY)	Coverage Limits	Coverage Type: Claims-Made* or Occurrence	Tail Endorsement In Effect?*	Are You Applying for a Tail?*
	/ - /	\$	( ) Claims-Made; ( ) Occurrence	( ) Yes; ( ) No	( ) Yes; ( ) No
	/ - /	\$	( ) Claims-Made; ( ) Occurrence	( ) Yes; ( ) No	( ) Yes; ( ) No

\*If you have or have had claims-made coverage prior to obtaining the Plan’s coverage, you should ensure that an extended reporting-period (a.k.a. "tail") endorsement from that indemnitor is secured.

**Important Notes**

The Plan would not cover claims arising from incidents that occurred prior to your retroactive date of the coverage provided to you by the Plan. The Plan would not cover incidents that were reported to any other responsible indemnitor and/or incidents that were reported on a date prior to your initial inception date of the coverage provided to you by the Plan. The Plan would not cover those incidents that, with your reasonable diligence, should have and/or could have been reported, to your other responsible indemnitors. It is important that you comply with the terms and conditions that are common of most claims-made coverages--Such terms and conditions usually require that you promptly report any incident, which would be covered by the terms of that coverage, that might result in a claim against you.

**Claim Experience**

Within the last 5 years, have you been involved in any (alleged) medical incident(s) for which a claim(s) or lawsuit(s) has been asserted against you and/or your (professional practice) corporation?

( ) No; ( ) **Yes--Please respond to the following:**

-For such incident(s) was a claim or lawsuit asserted against you and/or your corporation, which is **still open and pending?**

( ) No; ( ) Yes.

-For such incident(s) was an **out-of-court settlement** made on your and/or your corporation's behalf?

( ) No; ( ) Yes.

-For such incident(s) were you and/or your corporation assessed monetary damages (including compensatory and punitive damages) via a **judgment or verdict?**

( ) No; ( ) Yes.

If yes to any of the above, please provide information, below or on a separate attachment, for each (alleged) medical incident. The information that you provide should include the following: description of the claim; date of the (alleged) incident; current status; monetary amount of settlement, judgment, or verdict, if any; and other relevant information.

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**ACKNOWLEDGMENT, AUTHORIZATION, AND RELEASE -- All Applicants**

I authorize the release and exchange of information involving, but not limited to, the following: liability incidents or claims matters, damages, settlements, and judgments; hospital or other health-care-provider staff applications, associations, and privileges; professional duties; professional societies or associations; previous insurance carriers or other entities that have provided me with professional-liability coverage; hospital or medical-practice-group employment.

I authorize the release and exchange of information to/from the Lifespan Risk Services, Inc., and its representatives and agents to/from representatives and agents of Lifespan and the Plan, its affiliates and contracted services, and the representatives and agents of the organizations of which and for which I do and will engage, or have engaged, my professional practice and professional services.

I acknowledge and understand that the continuing of the Coverage is contingent on my continuing to meet the criteria for the Coverage.

If applicable, I acknowledge and accept the Lifespan Malpractice Plan's Eligibility Criteria concerning the Lifespan PO Members. If applicable, I acknowledge and accept the Lifespan Malpractice Plan's (annual) Certification of Compliance of the Eligibility Criteria concerning the Lifespan PO Members.

I acknowledge and understand that any changes in my professional practice (including, but limited to, medical-practice group employment/ relationship/FTE status, primary specialty, sub-specialty, etc.) during the indicated Coverage Period would need to be diligently communicated to the Lifespan Risk Services, Inc.

I acknowledge and understand that, should I need to terminate or cancel the coverage afforded by the Plan, I must request this termination in writing to include: The date of termination/cancellation, and a request to procure tail coverage if desired. The request must be signed, dated, and sent to the Lifespan Risk Services, Inc., for processing.

I acknowledge and affirm that the information that I have provided, within this Application and other attachments/ documentation or information that relates to this Application, is complete and accurate to the best of my knowledge.

I request that information presented in this Application to supplant any information previously submitted or provided to Lifespan Risk Services, Inc., and/or the Lifespan Malpractice Plan for purposes of underwriting Coverage and determining Coverage eligibility.

I request claims-made healthcare-provider professional-liability indemnification from Lifespan (Lifespan partner), via the Plan, for the indicated Coverage Period. I acknowledge that coverage other than healthcare-provider professional- liability coverage is neither express nor implied by this indemnification.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Applicant (Printed): \_\_\_\_\_