



For Elective Cosmetic Surgery Complications

-Application-

Administered By:

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PatientInsure

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PLEASE FAX, EMAIL OR OVERNIGHT ALL QUESTIONNAIRES TO THE ADDRESS LISTED

THIS QUESTIONNAIRE IS NOT FOR PROFESSIONAL LIABILITY INSURANCE

Coverage Underwritten By:

National Union Fire Insurance Company of Pittsburgh, Pa.

a member of

American International Companies®

Insurance Provided by Members of American International Group, Inc.

Instructions: Please type or print in ink all sections applicable to your surgical practice. Please attach additional documents requested.

A. APPLICANT (SURGEON) INFORMATION

1. Full Name: _____

2. Date of Birth: _____ 3. SS# _____

B. OFFICE INFORMATION

1. Office Contact(s): Office Manager: _____

Patient Representative: _____

Accounting: _____

2. Business Name: _____

3. Primary Business Address: _____

4. Billing Address (if different): _____

5. Office Phone: _____ Fax: _____

E-mail: _____ Web Address: _____

6. Type of Practice (circle): Solo Practitioner / Group (2-4 Surgeons) / Group (5 or more) / Multi-Specialty Group / Academic Practice / Other _____

7. Name all Surgeons practicing with you that perform Cosmetic Surgery:

C. STATE LICENSURE AND CERTIFICATION (Please list the states where you hold a current medical license)

State	License Number	% of Practice	Status

1. Are you Board Certified by an American Board of Medical Specialties (ABMS) Member Board?: Yes No

Name of Board(s) Certification: _____ Date Certified: _____

_____ Date Certified: _____

2. Are you Board Certified by the American Board of Oral and Maxillofacial Surgery (ABOMS)? Yes No

If you answered yes, please check all that apply. MD DO DDS
(Must have MD/DO designation with a DDS to qualify for PatientInsure)

3. Are you Board Certified by the American Board of Cosmetic Surgery (ABCS)? Yes No

4. Are you a Fellow of the American Academy of Cosmetic Surgery (AACS)? Yes No

If you answered no, what date will you become a Fellow with the AACS? _____

5. Please list all other associations and/or societies with which you are affiliated.

6. Have you ever been denied a medical license by any state, denied membership in a professional society, or denied certification by a specialty board? (If yes, an explanation on a separate sheet of paper must accompany this questionnaire) Yes No

7. Have you ever had your medical license, certification by a specialty board, membership in a professional society, or hospital privileges revoked, suspended or cancelled? (If yes, an explanation on a separate sheet of paper must accompany this questionnaire).
 Yes No

D. SURGICAL PRACTICE DESCRIPTION

Please answer all questions fully. All “yes” answers should be explained in full. Attach additional sheets if necessary.

1. The following list of cosmetic surgical procedures are **elective**, not reconstructive, and are covered under PatientInsure. Please estimate the number of each procedure performed per year. Each of these procedures must be performed under general anesthesia or IV sedation. **A minimum of 15 patients having one or more of the below procedures in an anesthetic event must be estimated and performed.**

- | | | |
|--------------------------|---------------------------|-----------------------|
| Abdominoplasty_____ | Cheek Implants_____ | Lower Body Lift_____ |
| Breast Augmentation_____ | Chin Augmentation_____ | Otoplasty_____ |
| Breast Lift_____ | Cosmetic Eye Surgery_____ | Rhinoplasty_____ |
| Breast Reduction_____ | Facelift_____ | Thigh Lift_____ |
| Brow Lift_____ | Tx of Gynecomastia_____ | Upper Arm Lift_____ |
| Buttock Lift_____ | Liposuction_____ | Hair Restoration_____ |

Total Estimate of Patients having these procedures during the next 12 Months:

2. Please indicate where these procedures were performed in the last 12 months:
Hospital: _____% Accredited Surgical Center: _____% Office-Based Operating Room: _____% Other: _____%

3. For each Outpatient Facility and Office Based Operating Room referenced in Item 2, Section D on page 3, list the facility and its accreditation (i.e. JCAHO, AAAHC, and AAAASF). For non-accredited facilities, please attach the most recent state inspection report if available. (You do not have to list information for hospitals.)

Facility Name and Location:	Accreditation:	Contact Name & telephone #

4. Do you have staff privileges at a Hospital or Accredited Surgical Center for all of the procedures listed in Item I, Section D on page 3?
 Yes No If No, please explain.

5. Has any Hospital or Accredited Surgical Center ever restricted, suspended or revoked your privileges?
 Yes No

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

7. Has any fee or professional relations complaints been registered against you with your medical association, hospital, licensing authority or professional society? Yes No

NOTE: PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER EXPLAINING ALL “YES” ANSWERS.

E. PROFESSIONAL LIABILITY INSURANCE INFORMATION

1. Current Medical Malpractice Company _____ Effective Date: _____

*******Note: Please attach the “Declarations” (front) page of your Medical Malpractice policy and a copy of your most recent certificate of insurance.**

2. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit for alleged malpractice?
If yes, have these been reported to your insurer?
- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*******Note: Please attach any claims information provided by your Medical Malpractice Insurance Company.**

3. Has your Medical Malpractice coverage ever been non-renewed or cancelled due to claims or nonpayment of premium?
 Yes No

If yes, please provide details. _____

PLEASE READ AND SIGN. I hereby declare that the above statements are true and that I have not knowingly suppressed or misstated any material facts. I authorize the Company to conduct any investigation to substantiate this information. I hereby agree that this questionnaire including my attachments thereto shall be the basis of any insurance contract issued by National Union Fire Insurance Company of Pittsburgh, PA (“the Company”).

I agree to notify PatientInsure if there is any future material change in any answer to this questionnaire, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician, firm or professional association.

I understand and agree that the completion of this questionnaire does not bind the Company to issue, nor me to purchase, a contract of insurance, provided however, if I am issued insurance by the Company and I purchase such contract of insurance, I understand and agree that any material misrepresentation or omission by me in this questionnaire may act to void such contract of insurance and may give the Company a right to rescind such contract.

Signature

Date Signed

PatientInsure Binder

As an applicant to be a Participating PatientInsure Surgeon, I ratify and affirm that I understand and agree that:

- A. ALL of my patients having one or more of the 18 Covered Procedures listed below MUST be enrolled in PatientInsure - there is no choice by the surgeon or the patient to accept or deny coverage.

- B. PatientInsure does not apply to those patients whose original procedure is either covered by other insurance or does not require general anesthesia or IV sedation.
- C. Representatives of the insurer have the right to review and audit any records and/or records of the policyholder that may have a bearing on this insurance. This would include but is not limited to any individual patient file and/or a CPT-4 report and/or similar type report.
- D. Letter C above is to ensure there is compliance with the PatientInsure program policy provisions. If the audit determines that any patients were not reported and paid by the surgeon as required, then premium must be paid within 30 days.
- E. Patients not covered by PatientInsure are not eligible for PatientInsure benefits.
- F. There is no coverage in effect prior to the policy's effective date.

Surgeon Signature

Witness Signature

Print Name

Print Name

Date Signed

Date Signed

*List of Covered Procedures

- Abdominoplasty
- Breast Augmentation
- Breast Lift
- Breast Reduction
- Browlift
- Buttock Lift
- Cheek Implants
- Chin Augmentation
- Cosmetic Eyelid Surgery
- Facelift
- Hair Restoration
- Treatment of Gynecomastia
- Liposuction
- Lower Body Lift
- Otoplasty
- Rhinoplasty
- Thigh Lift
- Upper Arm Lift

*under general anesthesia or IV sedation only