

PHYSICIANS REIMBURSEMENT FUND, INC.
A Risk Retention Group

APPLICATION FOR INSURANCE – MD

<i>Type(s) of coverage requested:</i>		Yes	No
Part A:	Patient Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Part B:	Prior Acts Coverage	<input type="checkbox"/>	<input type="checkbox"/>
Endorsement 1:	Legal Defense for Medical Board Proceedings	<input type="checkbox"/>	<input type="checkbox"/>
Endorsement 2:	Laboratory Facilities (not required for waived laboratory tests performed in physician's office)	<input type="checkbox"/>	<input type="checkbox"/>
Endorsement 3:	Physician Extenders (Surcharge for coverage other than PRF)	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Information:

1. Name: _____
CA Med. Lic. # _____ Expiration Date: _____
2. Type of practice or practice group: Solo Partnership Corporation Other
3. a) Name of practice or practice group: _____
b) Name of practice manager: _____
4. Contact information:
 - a) Primary office address: _____

 - b) Primary office telephone: _____
 - c) Direct office voicemail: _____
 - d) Office facsimile number: _____
 - e) Office Manager number: _____
 - f) Pager number: _____

- g) Mobile telephone: _____
- h) E-mail address: _____
- i) Home address: _____

- j) Home telephone: _____
5. Medical specialty: _____
6. Subspecialty (if applicable): _____
7. Has your specialty or type of practice changed in the last 3 years?
 Yes No
- If "Yes," please explain: _____

8. Date of Birth: _____ SS# _____
9. Medical School: _____ Date completed: _____
10. Internship _____ Date completed: _____
11. Residency: _____ Date completed: _____
12. Fellowship: _____ Date completed: _____
13. Specialty Society Memberships: _____

14. Hospital Staff Affiliations: _____

15. Teaching Appointments _____
16. Do you intend to practice more than 3 hours per week at any office or clinic (practice location) other than the primary office identified above?
 Yes No

If “Yes,” please provide the following information for each additional practice location:

- a) Office address: _____

- b) Office telephone: _____
- c) Office facsimile number: _____

17. Do you or your practice group intend to utilize any physician extenders (which for purposes of coverage includes nurse practitioners, nurse anesthetists, and midwives and any other person to whom a physician can lawfully delegate responsibility for performing specified medical procedures)?

- Yes No

If “Yes,” please provide the following information for each physician extender:

- a) Name: _____
- b) CA License No.: _____
- c) Professional Liability Insurer: _____
- d) Policy Expiration Date: _____
- e) Policy Limits: _____

Your physician extenders must have their own professional liability coverage either from PRF or their own insurer. If insured by other than PRF, there is a monthly surcharge. Applications for PRF for physician extender coverage are available on request:

- Please send a physician extender application.
 Not applicable

18. Do you or your practice group intend to utilize any physicians as locum tenens?

- Yes No

Each PRF *approved* locum tenens will be covered under your policy of insurance for services performed in your office at no additional premium. Applications for locum tenens approval are available on request:

- Please send a locum tenens application.
 Not applicable.

19. Have you ever received any claim, demand for compensation, notice of intent to sue, summons or demand for arbitration arising from professional services rendered?

Yes No

If “Yes,” please provide the following information for each such claim:

- a) Date of Incident: _____
- b) Nature of Claim: _____
- c) Date Resolved: _____
- d) Nature of Resolution (including amount of any settlement or judgment or award):

Use a separate page if necessary.

20. Names and dates of coverage of any previous professional liability insurers. (An authorization to obtain your liability history from prior insurers is attached.)

Name of Insurer

Dates of Coverage

21. Has your professional liability coverage ever been cancelled or not renewed?

Yes No

If “Yes,” please provide the name of the insurer and the reasons given (if any) for the cancellation or non-renewal:

22. Identify any special procedures you perform or participate in which could be regarded as innovative, experimental or for which long-term follow-up has not been established:

23. If you are American Board Certified, please provide your date of certification and expiration:

24. If you are not American Board Certified:

a) Have you ever been denied Board Certification after taking the examination for certification?

Yes No

b) Are you American Board eligible in your specialty?

Yes No

Expiration date: _____

c) Do you plan to take your American Board Certification Examinations?

Yes No

Planned date: _____

25. Has your license to practice your profession in any jurisdiction or your Drug Enforcement Agency or other controlled substances authorization ever been limited, suspended, revoked, denied or subjected to probationary conditions, or have proceedings toward any of those ends been instituted?

Yes No

26. Have you ever voluntarily relinquished any medical staff membership, clinical privileges, professional license(s) or narcotics registration under threat of disciplinary action?

Yes No

27. Have you ever been denied membership on any hospital medical staff, or advancement in medical staff status, or has such a denial been recommended by a standing medical staff committee or governing board?

Yes No

28. Has your medical staff membership or medical staff status or your clinical privilege(s) at any hospital ever been limited, suspended, revoked, not renewed or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a standing medical staff committee or governing board?

Yes No

29. Has your request for any specific clinical privileges ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a standing medical staff committee or governing board?
- Yes No
30. Do you have any mental or physical health problems that may affect your ability to practice or the quality of your practice?
- Yes No
31. Have you ever been denied certification, or has your eligibility status changed with respect to certification, by a specialty board?
- Yes No
32. Has any investigation, review or audit by a provider organization (IPA, MSO or HMO) or other credentialing agency ever resulted in penalties, restrictions, or modification of your privileges or provider status?
- Yes No
33. Have you ever been convicted of a felony or have any felony charges been filed against you?
- Yes No

If the answer to any of questions 25 through 33 is “Yes,” or if you wish to provide any other pertinent information, please include full details on a separate page.

I certify that the information contained in this application is complete and correct to the best of my knowledge, and I understand that PRF will be relying upon this information in reaching its decision whether to extend insurance coverage to me.

Name: _____

(Please print)

Signature: _____

Date: _____

AUTHORIZATION FOR THE RELEASE OF INSURANCE INFORMATION

The undersigned hereby authorizes and requests the release by each and any of his/her former or present professional liability insurance providers of any and all information, whether confidential or otherwise, requested by the Physicians Reimbursement Fund, Inc., A Risk Retention Group or its representatives.

For purposes of the above, a copy of this authorization shall be sufficient accompanying any request for information. This Authorization shall be effective for six months from the date executed.

Date: _____

Signature: _____

Name: _____
(Please print)

Address: _____

Physicians Reimbursement Fund, Inc.,
A Risk Retention Group
711 Van Ness Avenue, Suite 430
San Francisco, CA 94102
Attention: June Riley

Re: Sphargis Inc. Share Purchase

Dear Ms. Riley:

The undersigned applicant for insurance hereby applies for one share of Class A stock in Sphargis Inc., a California corporation, having a par value and a purchase price of \$1.00 (one dollar). I acknowledge that my rights and obligations with respect to this stock are as described in the Articles of Incorporation as amended and in the Bylaws of Sphargis Inc., copies of which are available upon my request. I also acknowledge that I must continue to hold this share so long as I am an insured of the Physicians Reimbursement Fund, Inc., A Risk Retention Group, (PRF) and that the share is subject to repurchase at its original price in the event I cease to be an insured.

Yours truly,

Signature

Name (Print)

Address

City/State/Zip Code

Telephone

Date

Please return the completed application (including attachments) together with the following:

- A copy of Applicant's most current curriculum vitae
- A check for \$200 made out to the PRF (non-refundable application fee)
- A check for \$1 made out to Sphargis, Inc. for required share purchase

Mail or deliver to:

Physicians Reimbursement Fund Inc., A Risk Retention Group

711 Van Ness Avenue, Suite 430

San Francisco, CA 94102

415/921-0498 (Telephone) 415/921-7862 (Facsimile)

NOTICE:

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.