Complete this form ONLY if you will be added to HRRMC's Shared Limits PLI coverage as either an employee or independent contractor.

A copy of your CV must be attached.

NOTICE: This form has been partially completed with HRRMC-related information. ALL remaining information MUST BE completed by applicant.

Salida Hospital District d/b/a HRRMC IS a governmentally immune entity and, therefore, an applicant who will be employed by HRRMC MUST complete and sign the last page/acknowledgment page of this application relating to that status.

COPIC
Better Medicine • Better Lives

7351 E. Lowry Blvd., Denver, CO 80230
P.O. Box 17540, Denver, CO 80217-0540
P: 720-858-6000 | TF: 800-421-1834 | F: 720-858-6001
callcopic.com

DISCLOSURE FORM CLAIMS-MADE POLICY
IMPORTANT NOTICE TO POLICYHOLDER

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT DESCRIBES SOME OF THE MAJOR FEATURES OF OUR CLAIMS-MADE POLICY FORM. READ YOUR POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

YOUR POLICY

Your policy is a claims-made policy. It provides coverage only for injury or damage occurring after the policy retroactive date (if any) shown on your policy and the incident is reported to your insurer prior to the end of the policy period. Upon termination of your claims-made policy an extended reporting period option is available from your insurer.

There is no difference in the kind of injury or damage covered by occurrence or claims-made policies. Claims for damages may be assigned to different policy periods, depending on which type of policy you have.

If you make a claim under your claims-made policy, the claim must be a demand for damages by an injured party and does not have to be in writing. Under most circumstances, a claim is considered made when it is received and recorded by you or by us. Sometimes, a claim may be deemed made at an earlier time. This can happen when another claim for the same injury or damage has already been made, or when the claim is received and recorded during an extended reporting period.

PRINCIPAL BENEFITS

This policy provides for defense and indemnification of covered claims arising from medical incidents or staff privileges incidents up to the maximum dollar limit specified in the policy.

The principal benefits and coverages are explained in detail in your claims-made policy. Please read it carefully and consult your insurance producer about any questions you might have.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS

Your claims-made policy contains certain exceptions, reductions and limitations. Please read them carefully and consult your insurance producer about any questions you might have.

RENEWALS AND EXTENDED REPORTING PERIODS

Your claims-made policy has some unique features relating to renewal, extended reporting periods and coverage for events with long periods of potential liability exposure. If there is a retroactive date in your policy, no event or occurrence prior to that date will be covered under the policy even if reported during the policy period. It is therefore important for you to be certain that there are no gaps in your insurance coverage. These gaps can occur in several ways. Among the most common are:

1. If you switch from an occurrence policy to a claims-made policy, the retroactive date in your claims-made policy should be no later than the expiration date of the occurrence policy.
2. When replacing a claims-made policy with a claims-made policy, you should consider the following:
    a. The retroactive date in the replacement policy should extend far enough back in time to cover any events with long periods of liability exposure, or
    b. If the retroactive date in the replacement policy does not extend far enough back in time to cover events with long periods of liability exposure, you should consider purchasing extended reporting period coverage under the old claims-made policy.
3. If you replace this claims-made policy with an occurrence policy, you may not have insurance coverage for a claim arising during the period of claims-made coverage unless you have purchased an extended reporting period under the claims-made policy. Extended reporting period coverage must be offered to you by law for at least one year after the expiration of the claims-made policy at a premium not to exceed 200% of your last policy premium.

CAREFULLY REVIEW YOUR POLICY REGARDING THE AVAILABLE EXTENDED REPORTING PERIOD COVERAGE, INCLUDING THE LENGTH OF COVERAGE, THE PRICE AND THE TIME PERIOD DURING WHICH YOU MUST PURCHASE OR ACCEPT ANY OFFER FOR EXTENDED REPORTING PERIOD COVERAGE.

FOR COPIC USE ONLY	
Last Name	**UW/Date**
Specialty	

COPIC
Better Medicine • Better Lives

Hospital Employed/Contracted Physician COPIC Application for Medical Professional Liability Insurance

Supplement to the Colorado Health Care Professional Credentials Application (CHCPCA)

Claims-made coverage

With your completed application, you must submit the following information:

- Curriculum Vitae (C.V.)
- A complete copy of the Colorado Health Care Professional Credentials Application signed and dated within the past ninety (90) days.

COPIC Insurance Company
7351 Lowry Boulevard ■ Denver, CO 80230
phone 720/858-6000 ■ *fax* 720/858-6004 ■ *toll free* 800/421-1834 ■ www.callcopic.com

APPLICANT DATA

1. Last name	First name	M.I.
2. DOB / /	3. SSN - -	4. Gender ❑ M ❑ F
5. Hospital Employer **Salida Hospital District d/b/a Heart of the Rockies Regional Medical Center**		

COVERAGE REQUESTED

Liability Limits: Physician shares in the limit of liability available to the hospital under HPL Coverage A.

6. Requested Effective Date

LICENSES

7. For **all** active state medical licenses listed on page 7 of the Colorado Health Care Professional Credentials Application, please provide the number of hours you currently work per week in each state.

   State **COLORADO** ____ # hours/week _____

   State _____ # hours/week _____

   State _____ # hours/week _____

PROFESSIONAL LIABILITY INSURANCE HISTORY

8. Are you canceling your current policy? ..... ❑ Yes ❑ No

9. If your current insurance is claims-made, will "tail" coverage be purchased?..... ❑ Yes ❑ No

* This hospital policy will NOT provide any coverage for any past medical practice. Coverage will only apply while the physician is acting within the course and scope of duties for the hospital.

PRACTICE HISTORY

10. Percentage of your employment devoted to your Specialty _____

11. Percentage of your employment devoted to your Subspecialty _____

12. Are you board eligible by a member board of the American Board of Medical Specialties or the American Osteopathic Association?..... ❑ Yes ❑ No

PRACTICE CHARACTERISTICS

13. Average number of hours worked per week for the hospital ❑ ≤ 15 ❑ 16-20 ❑ 21-25 ❑ ≥ 26

    If you are practicing part time (less than 26 hours/week), please describe all other professional or business activities. _____

    _____

14. Do you maintain professional liability coverage for your "other professional or business activities?" ..... ❑ Yes ❑ No

15. Do you participate in telemedicine? ..... ❑ Yes ❑ No

(For purposes of this question, telemedicine is defined as "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual patient as a result of transmission of individual patient data by electronic means." Telemedicine does not include an informal consultation provided without compensation or expectation of compensation, nor does it include those services described above which are rendered in a bona fide emergency.)

If "yes," please explain in the Notes Section and include a list of state(s) and license number(s).

16. If you are a radiologist or pathologist, do you or will you read, interpret or diagnose films, slides or specimens taken of patients who reside outside the state of Colorado? ❑ Yes ❑ No ❑ N/A

If "yes," please indicate the state(s) or foreign country(ies) in which the patients being treated reside:

_____

And the number of hours per week you will devote in each state or foreign country:_____

_____

17. Have there been any changes in your specialty, classification or practice activity within the past ten years? ..... ❑ Yes ❑ No

If "yes," please describe the nature of changes in specialty, classification or practice activities. _____

_____

_____

If additional space is needed, please use the Notes Section.

PROCEDURES PERFORMED

All "yes" answers require explanation in the Notes Section.

18. Do you perform bariatric surgery? ..... ❑ Yes ❑ No

If "yes," please indicate the percentage of your time devoted to your bariatric practice. _____ %

19. Do you assist at surgery? ..... ❑ Yes ❑ No

20. In your practice, do you perform procedures or use equipment not used by a majority of physicians in your specialty who practice in Colorado? ..... ❑ Yes ❑ No

21. Do you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure? ..... ❑ Yes ❑ No

22. Do you supervise CRNAs who provide general anesthesia? ..... ❑ Yes ❑ No

23. Do you perform obstetrical procedures? ..... ❑ Yes ❑ No

24. If you answered "yes" to question 23, please indicate the average number of deliveries performed per year _____ and the average number of C-sections performed per year. _____

If you answered "yes" to question 23, do you hold a current certification in Advanced Life Support in Obstetrics (ALSO)? ..... ❑ Yes ❑ No

If "yes," please provide the expiration date._____

25. If you are a Family Practitioner performing obstetrics, do you have privileges to perform C-sections at the hospital where you are employed/contracted? ..... ❑ Yes ❑ No

Important: *If "no," please provide full details of the back-up arrangements including coverage for VBAC patients.*

26. Do you practice in an Emergency Department (ED)? ..... ❑ Yes ❑ No

If "yes," please indicate number of hours per week _____ and answer the following:

a. Do you only provide on-call coverage to the ED? ..... ❑ Yes ❑ No

b. Do you provide ED specialty backup/consult only? ..... ❑ Yes ❑ No

c. Do you work in the ED just to maintain hospital privileges? ..... ❑ Yes ❑ No

d. Do you work in the ED for compensation for activities other than those described in 26 a, b, and c above? ..... ❑ Yes ❑ No

27. Do you perform "invasive" procedures? ..... ❑ Yes ❑ No

"Invasive" refers to procedures by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation. If "yes," list all such procedures:

Procedure	**Resident-Trained?**		**Hospital Privileges?**	
_____	❑ Yes	❑ No	❑ Yes	❑ No
_____	❑ Yes	❑ No	❑ Yes	❑ No
_____	❑ Yes	❑ No	❑ Yes	❑ No
_____	❑ Yes	❑ No	❑ Yes	❑ No
_____	❑ Yes	❑ No	❑ Yes	❑ No
_____	❑ Yes	❑ No	❑ Yes	❑ No
_____	❑ Yes	❑ No	❑ Yes	❑ No
_____	❑ Yes	❑ No	❑ Yes	❑ No

28. Do you perform:

Prenatal care beyond the first trimester? ..... ❑ Yes ❑ No

Second-trimester abortions? ..... ❑ Yes ❑ No

C-Sections? ..... ❑ Yes ❑ No

Angiography? ..... ❑ Yes ❑ No

Breast biopsy by surgical incision? ..... ❑ Yes ❑ No

Cardiac catheterization? ..... ❑ Yes ❑ No

Liposuction surgery using the tumescent technique? ..... ❑ Yes ❑ No

Liposuction surgery using any technique other than tumescent? ..... ❑ Yes ❑ No

Reduction of open fractures? ..... ❑ Yes ❑ No

Reduction of undisplaced closed fractures? ..... ❑ Yes ❑ No

Reduction of displaced closed fractures? ..... ❑ Yes ❑ No

"Undisplaced" refers to fractures in which a fracture line is visible, but the alignment of the bone has not been displaced. "Displaced" refers to fractures in which the alignment of the bone has been displaced, but the continuity of the bone has not been altered.

29. Please describe your practice (choose only one): ❑ Hospitalist ❑ Intensivist/Critical Care Specialist ❑ None of the above

If you answered "None of the above" to question #29, please skip the next two questions and proceed to question #32.

30. Please indicate the percentage of your total practice devoted to in-patient care of hospitalized patients: _____% and indicate the _____ % in intensive or critical care and the _____ % hospitalized, but not in intensive or critical care.

31. Please describe your practice's policy regarding continuity of care with patient "handoffs" at the end of shifts:_____

_____

32. What percentage of your practice is devoted to aesthetic or cosmetic procedures? _____% ❑ N/A

NON-COVERED PROCEDURES

33. **COPIC will not insure the following procedures:**

a. Autologous fat injections into penises
b. Chelation therapy (other than for treatment of heavy metal poisoning)
c. Chymopapain disc injection
d. Elective home delivery
e. Intravascular absolute alcohol embolization except for renal pathology
f. Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity
g. Mesotherapy
h. Rapid opiate detoxification
i. Sclerotherapy (the injection of sclerosing agents) into the vertebral column
j. Sperm banks for other than interim storage for insemination of your own patients
k. Transsexual surgery
l. For non-physicians you supervise or employ, the management of active labor and any subsequent delivery for Vaginal Birth after Caesarean (VBAC) patients unless a responsible physician is physically on premises and immediately available for the entire course of care
m. Obstetric ultrasound images or videos created solely for nonmedical reasons or without an ultrasound report for the medical record or any nonmedical use of ultrasound imaging, such as "keepsake ultrasounds"

OTHER INFORMATION

All "yes" answers require explanation in the Notes Section.

34. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law?
Note: You must answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs..... ❑ Yes ❑ No

35. Have you incurred or suffered any chronic illness or physical injury in the past 24 months OR are you currently a registrant in any state's medical marijuana registry?.... ❑ Yes ❑ No

36. Have you ever failed any licensing or Board certification examinations?..... ❑ Yes ❑ No

37. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, health plan, managed care organization or other medical review committee?..... ❑ Yes ❑ No

38. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? ..... ❑ Yes ❑ No

39. Do you recommend medical marijuana? ..... ❑ Yes ❑ No

If "yes," please answer all of the following questions:

a. For all patients for whom you recommend medical marijuana, do you have a physician-patient relationship in which you have completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination?..... ❑ Yes ❑ No

b. For all patients for whom you recommend medical marijuana, are you available to provide follow-up care and treatment, including examination of the patient, to assess the efficacy of the medical marijuana? ..... ❑ Yes ❑ No

c. For all patients for whom you recommend medical marijuana, do you specify the chronic or debilitating disease or condition and, if known, the cause or source of the disease or condition?..... ❑ Yes ❑ No

d. Do you maintain documentation of the subjective and objective information gathered from your examination of each patient which supports your diagnosis and recommendation for medical marijuana?..... ❑ Yes ❑ No

e. What percent of your total practice is devoted to recommending medical marijuana?_____ %

f. In the past 12 months, for how many patients have you recommended medical marijuana?_____

CLAIMS INFORMATION

Important information regarding questions 40 and 41 (including sub-questions):

1. The word "claim" as used in Questions 40 and 41 below refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to question 40 or 41 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 7).

40. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? ❑ Yes ❑ No

41. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:
    a. A request for records from a patient and/or attorney related to an adverse outcome? ❑ Yes ❑ No
    b. A letter from an attorney regarding your medical treatment of a patient? ..... ❑ Yes ❑ No
    c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ..... ❑ Yes ❑ No
    d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ..... ❑ Yes ❑ No
    e. Any other circumstances that might reasonably lead to a claim or suit? ..... ❑ Yes ❑ No

42. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ..... ❑ Yes ❑ No ❑ N/A*

**For purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

    a. If "yes," how many? _____ Please attach documentation of all such reports.
    b. If "no," please explain in the Notes Section.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy these pages. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name:_____
2. Date reported to insurance company:_____
3. Name of insurance company:_____
4. Date of incident and your treatment:_____
5. Allegations:_____

   _____

   _____
6. What is the present condition of the patient? _____

   _____

   _____
7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... ❑ Yes ❑ No

8. Status of claim (check applicable answer):

❑ Suit threatened, no action taken ❑ Suit filed but dropped by claimant ❑ Summary judgment in your favor	Court outcome in your favor: ❑ Yes ❑ No	❑ Awaiting mediation ❑ Awaiting court action
❑ Suit settled out of court a. Date claim paid:_____ b. Amount paid: $ _____ c. Did you want to settle this claim? ❑ Yes ❑ No	Court outcome in favor of plaintiff: Amt. of Loss Payment: $_____	Reserve Amount: $_____

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ❑ Yes ❑ No

   If "yes," amount was $_____

Signature:_____ **Date**:_____

Name (Printed):_____

NOTES

Question #

HOSPITAL EMPLOYED/CONTRACTED PHYSICIAN/SURGEON STATEMENT OF UNDERSTANDING SHARED LIMIT OF LIABILITY

I hereby understand and agree that the attached application is not an application for an individual policy of insurance. I understand that I will not be extended any individual limits of insurance, but rather I will share in the limit of insurance available to the hospital, who is the named insured on the policy.

I further understand that the insurance available under this policy only applies to me as an employed or contracted physician of the hospital while I am acting within the course and scope of duties for the hospital.

SIGN HERE

Physician signature _____ Date _____

Please PRINT your name _____

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! I understand and agree that as a condition of being insured, I accept the requirement to submit to a health and skills assessment by a physician of COPIC's choice. This assessment may be required at COPIC's discretion.

I hereby declare and warrant that all answers and statements herein given are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. I understand that these answers and statements are material and as such will be relied upon in the determination by the company to grant my liability insurance. If I or any other person making application or providing information on my behalf misstate or fail to disclose any pertinent information, my application may be declined. If my application is approved and it includes any misstatement or failure to disclose pertinent information, COPIC has the right to cancel my insurance. COPIC also has the right to decline coverage for a specific claim if COPIC would have declined to issue insurance or limited my coverage if I had not made the misstatement or omission.

Further, I recognize and agree that as a prerequisite to acceptance of this application and consideration for granting of liability insurance, COPIC Insurance Company and/or its assigns may conduct a peer review investigation of me and/or my practice. As part of such peer review investigation, I consent to the release of any prior Practice Quality Report and to periodic chart and medical record reviews conducted by Practice Quality, as COPIC may request or direct. I agree to abide by any recommendations arising from that review. I have been provided, understand, and will comply with the Participatory Risk Management Guidelines of COPIC Insurance Company.

I authorize any state board of medical examiners or licensure, hospital board or committee, hospital records department, insurance company, professional society, past or present, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC Insurance Company or its assigns. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC Insurance Company policy, I hereby consent to COPIC Insurance Company's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations, professional liability insurance carriers, and state and federal regulatory entities, including but not limited to boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank and to the fullest extent permitted by law, hereby release all providers of such information, including COPIC Insurance Company, its employees and agents, from any and all liability therefore. This release applies to the following information: my name, business address, social security number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank.

I have received the Claims-Made Disclosure Notice. I understand that if my application for coverage is approved, the disclosures described in the Notice will apply to my coverage with COPIC.

Physician signature _____ Date _____

Please PRINT your name _____

WE SUGGEST YOU RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

HOSPITAL EMPLOYED PHYSICIAN/SURGEON STATEMENT OF UNDERSTANDING COLORADO GOVERNMENTAL IMMUNITY

Note: *Contracted physicians should not sign this page. Only employees of a governmentally immune facility enjoy governmental immunity.*

I hereby understand that my employer for this application of insurance is a governmental entity covered by Colorado's Governmental Immunity Statute (CRS 24-10-101 et. Seq.). As such the limits of liability for all actions which are covered by the provisions for CRS 24-10-101 et. Seq. are $150,000 for one person injured in a single occurrence; $600,000 for injury to 2 or more persons in a single occurrence, except that no single person may recover in excess of $150,000. I agree to 1.) not waive immunity under the statute, and to 2.) allow COPIC to assert all defenses provided for under the statute.

SIGN HERE

Physician signature _____ Date _____

Please PRINT your name _____

Third Party Payor Enrollment-NPI and CAQH

The following requested information is necessary to initiate third-party payor enrollment and this information is not a part of your CHCPCA (Colorado Healthcare Professional Credentials Application).

For your Medicare online application, HRRMC requires your NPI User Name and Password.* If you do not know your NPI User Name and Password, call the NPI Enumerator at 800.465.3203.

Username: _____

Password: _____

Your Medicare application also requires your Country and State of birth.

Country of Birth: _____

State of Birth: _____

HRRMC Medical Staff Office and/or Central Billing Office staff has permission to update my NPI information as updates necessitate. **Initial _____ Date _____**

Most third-party payors use CAQH (Council for Affordable Quality Healthcare) for payor enrollment processes. CAQH provides an online database for providers and payors to make the payor enrollment process more efficient. **HRRMC requires your CAQH Provider ID, Username, and Password.***

CAQH Provider ID: _____

Username: _____

Password: _____

HRRMC Medical Staff Office and/or Central Billing Office staff has permission to update my CAQH information as updates necessitate. **Initial _____ Date _____**

If you do not know your CAQH Provider ID, Username, or Password, call CAHQ at 888.599.1771.

*These step(s) can only be completed by you, as the provider. You will be asked confidential, protected identifying information in order to receive the above information. This could include your SSN, DOB, CO state license number, or other protected information in order to identify you.

NOTE: If you will ONLY be providing hospital-based services and will not be seeing patients in a clinic setting, you DO NOT need to complete the CAQH information section.