

**FLORIDA HEALTH PROFESSIONALS
LEGAL EXPENSE INSURANCE, INC.**

APPLICATION FOR GROUP MEDMAL LEGAL EXPENSE INSURANCE

(Please complete for each licensed or certified employee falling under the Group Policy)

Please Print

VI. LICENSE HOLDER INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Suffix: _____ License Number: _____ Social Security Number: _____

Practice Name: _____ Occupation/Specialty: _____

Primary Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Telephone Number: (____) _____ Primary Facsimile Number: (____) _____

E-Mail Address: _____ Date of Birth: _____

VII. PROFESSIONAL INFORMATION (a Curriculum Vitae may be attached)

A. Please provide the name and address information for each facility and other affiliations that you currently hold courtesy, staff, or other privileges.

<u>Facility/Hospital Name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Privilege Type</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. Please provide the names of all medical, professional or association memberships:

<u>Medical Memberships</u>	<u>Professional Memberships</u>	<u>Association Memberships</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. Please describe in detail the nature of all procedures and techniques that you currently perform or intend to perform within the next 12 months whether it is office, hospital, surgical center, or other facility environment. If you perform surgery, indicate the number of procedures performed as the primary and/or assisting surgeon. Indicate the level of office surgery procedures you perform, if applicable. Use a separate sheet if necessary.

VIII. DISCIPLINARY ACTIONS (Please circle your response to the following questions. If you answer "Yes" to any of these questions, you must provide a detailed explanation on a separate sheet. Please be sure to indicate the final outcome of any proceeding, including the amount of fines or penalties paid).

- A. Within the last ten (10) years, have you ever had any staff privileges denied, suspended, revoked, restricted or asked to resign from any facility? Yes or No
- B. Within the last ten (10) years, have you ever had any sanctions taken against you or received notice of termination as a supplier of services by a specialty board, Medicare, Medicaid, or OSHA? Yes or No
- C. Within the last ten (10) years, have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature? Yes or No
- D. Within the last ten (10) years, have you ever had any professional license or certification revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state or country? Yes or No
- E. Within the last ten (10) years, have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime(misdemeanors and felonies) in any jurisdiction? Yes or No
- F. Within the last ten (10) years, have you ever been criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? Yes or No
- G. Within the last ten (10) years, have you ever been warned or called before the U.S. Drug Enforcement Agency (including the revocation or suspension of a DEA registration)? Yes or No
- H. Within the last ten (10) years, have you ever had a liability claim or action for personal injury settled or adjudicated? Yes or No
- I. Are you currently subject of a lawsuit, insurance claim or investigation arising from your professional activity and/or is there reason to believe you will be subject to a lawsuit , insurance claim or investigation by a federal or state governing authority? Yes or No

IX. PROFESSIONAL LIABILITY INSURANCE

Please identify your current professional liability insurance carrier and the limits of the policy.

_____ If you are self-insured, please check this box .

X. AFFIDAVIT

- I agree that the information contained herein is being relied upon in consideration for this application for legal expense insurance.
- I declare, under the penalty of perjury, that these statements are true and correct.
- I have not withheld or misstated any information contained in this application.
- I further recognize that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

XI. SIGNATURE

Signature Printed Name Date

Please return this completed form and any supporting documentation to FHPLEI, Inc.

For Office Use Only	
Fl. Licensed Insurance Agent Name (Please print): _____	Lic. #: _____