Trinity Physician Insurance
100 N Lake Ave. # 205
Pasadena CA 91101
Tel: 877 257 1619
Fax: 888 317 2991

Agency: **Trinity Physician Insurance**

Agent: **Joseph Hong**

Email to: joe@trinityphysician.com

Request for Indication *(Please note: not all questions apply)*

Name: _____ **Designation/Title:** ☐MD ☐DO ☐DDS/DMD ☐ DC _____(Other)

Primary Practice _____ *Street* Date of Birth _____

Address: _____ *City State Zip* **County:** _____

Requested EFFECTIVE Date: _____ **Specialty:** _____%

Requested RETRO Date: _____ **Sub Specialty:** _____ %

Desired LIMITS: _____/_____ **Surgery:** ☐ None ☐ Minor ☐ Major

DEDUCTIBLE: ☐ $0 ☐ $5,000 ☐ $15,000

States Requesting Coverage In:

Number of Claims in last 10 years: _____ **State:** _____ **% of Practice:** _____

Claim Status: # of _____ **Open** _____ **Closed** **State:** _____ **% of Practice:** _____

Number of Board Actions in last 10 years:_____ **Number of Procedures per week:**_____

Number of Hours working per week: _____ **Number of Deliveries (if applicable):** _____

Number of Patients per week: _____ **Number of Reads (if applicable):** _____

Do you want coverage for your Entity or Allieds: ☐ Y ☐ N **Current Carrier:** _____

Entity/Allied Name: _____ **Expiring Premium: $**_____

Do you perform Cosmetic Surgery: ☐ Y ☐ N _____% **Aesthetics or Laser Procedures:** ☐ Y ☐ N _____%

_____% Elective _____% Reconstructive **Describe:** _____

Do you perform Bariatric Procedures: ☐ ☐ N **Do you practice in Correction Facilities:** ☐ Y ☐ N

Do you perform Telemedicine: ☐ Y ☐ N **In what States:**_____ _____ _____ _____ _____ _____

Agent Notes: _____

Do you practice in Nursing Homes: ☐ Y ☐ N_____% **Do you want coverage for Medical Director:** ☐ Y ☐ N

** This is for indication puposes only, applicants are subject to full underwriting review.*

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each. Attach additional sheets if needed for adequate explanation. 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 ☐ 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 your favor: ☐ Jury verdict ☐ Directed verdict Court outcome in favor of plaintiff: ☐ Jury verdict ☐ Directed verdict Amt. of loss payment: _____	Unresolved/Open Claim: ☐ Awaiting mediation ☐ Awaiting court action Reserve Amount: _____

9. Name and address of the attorney assigned to your case: _____

   _____
10. 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 _____
11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____

    _____

    _____

    _____

Signature: _____ **Date:** _____

Name (Printed): _____