



P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmlt.org

ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION IN THE RESIDENTS/FELLOWS TRAINING PROGRAM

Thank you for applying with TMLT. We know that you have a choice when purchasing medical liability insurance and we appreciate the opportunity to earn your business.

Completing and submitting your application:

- **Completion of one year of residency training (internship) is required before you can apply.**
- You must be a member of the Texas Medical Association or have a membership application pending to obtain coverage through TMLT. To start this process, please visit the TMA web site www.texmed.org or call 1-800-880-1300.
- Remember to sign and date your application once it is complete.
- Please review the *Business Associate Agreement*.
- Enclose a copy of your current *Curriculum Vitae*.
- Please complete your Trust Rewards enrollment form. For information please visit www.tmlt.org/trustrewards

Our website has a wealth of information on products and services we offer, including Coverage types, Risk Management, Claims, and information about TMLT. Be sure and check out our FAQs.

We want to make your application experience as simple as possible. If you have any questions during the process, we will be happy to assist you. Call 1-800-580-8658 and ask for Sales and Business Development.

Payment Options

Consider which billing and payment options are right for you. Billing can be invoiced monthly or quarterly as a recurring automatic draft using your Visa, MasterCard, American Express credit cards or by bank draft. If no billing option is chosen, you will be invoiced quarterly. Please visit www.tmlt.org to select and set up your payment option or call Customer Service at 1-800-580-8658 ext. 5050 for assistance.



TEXAS MEDICAL LIABILITY TRUST

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INDIVIDUAL APPLICATION FOR RESIDENTS/FELLOWS
PROFESSIONAL LIABILITY COVERAGE – TRAINING PROGRAM

PLEASE TYPE OR PRINT IN BLACK INK.
ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

POLICY NUMBER: (For Trust Use Only)

A. First name, Middle name, Last name, Maiden / Other names, Date of birth, Texas medical license, Social security number, Office phone, Office fax, Home phone, Cell phone, Professional email address, Personal email address, Professional website address, Preferred method of contact, Home address, City, State, Zip

B. Please list the locations where you will practice during your training program: 1. Address, City, State, Zip, County; 2. Address, City, State, Zip, County

C. Preferred billing address: home, primary office, other; Other billing address, City, State, Zip; Preferred mailing address: home, primary office, other; Other mailing address, City, State, Zip

D. 1. I am a: Resident or Fellow; Medical Specialty; 2. Date Residency completed: Month, Day, Year; Date Fellowship completed: Month, Day, Year; 3. Texas Medical Association membership is required. Are you currently a member or is membership pending? Yes No

E. Medical Education

Medical school	Degree/Specialty
City/State	Dates attended
Internship school/Hospital	Specialty
City/State	Dates attended
Residency school/Hospital	Specialty
City/State	Dates attended
Fellowship school/Hospital	Specialty
City/State	Dates attended

F. Requested coverage effective date 12:01 a.m.

Month	Day	Year
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Professional Liability Coverage: Please check the limits of liability requested. Occurrence limits indicated are for Each Claim/All Claims

\$100,000/\$300,000
 \$200,000/\$600,000
 \$500,000/\$1,000,000

G. Do you assist in major surgery? Yes No **Do you perform major surgery? Yes No**

Describe in detail the curriculum that will be followed over the next twelve months.

H. Additional information Note: If you answer **YES** to **ANY** of the following questions, **PLEASE PROVIDE DETAILS ON PAGE 4.**

1. Have any of the following ever been under review or investigation, revoked, denied, suspended, voluntarily surrendered, or limited in any way:
 - a. Your medical license or permit to prescribe drugs? Yes No
 - b. Your privileges at any hospital, clinic, or other facility? Yes No
 - c. Your Medicare / Medicaid accreditation or certification? Yes No

2. Have you ever been:
 - a. Treated for alcohol or substance abuse? Yes No
 - b. Diagnosed with any mental illness? Yes No
 - c. Diagnosed with or had a chronic illness or physical impairment that affected your ability to practice medicine? Yes No

3. Have you ever been indicted, charged, or convicted of a crime other than a minor traffic violation? Yes No

4. Do you dispense or prescribe medications or use medical devices that have been disapproved by the FDA in the treatment or care of human beings? Yes No

5. Have any professional relations or fee complaints ever been made against you by a medical association, hospital or licensing authority? Yes No

6. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled, or non-renewed? Yes No

7. Are you aware that your present carrier plans to restrict, surcharge, cancel, or non-renew your coverage? Yes No

8. Have any lawsuits (other than medical and auto liability suits) been filed against you in the last 10 years? Yes No

9. How many professional liability claims have **ever** been brought against you? Note: This includes notice of intent to sue and written demand from a patient or a lawsuit. Complete the information for **each** claim or suit on **page 4.** # _____

AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any policy is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding. **I understand any policy issued by TMLT will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMLT any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: Texas Medical Board; any other licensing agency; Texas Medical Association; any other state medical association or organization; any county medical society; any specialty medical society or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability and/or Premises Liability Coverage. I further authorize TMLT and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

This application incorporates by reference the terms and conditions of TMLT's HIPAA-HITECH Business Associate Agreement (reviewable at www.tmlt.org/appdocs), copies of which will be provided to me upon request. By signing and accepting below, I consent to the terms and conditions of these documents and agreements.

By submission of this application, or by acceptance of coverage from TMLT, I hereby release TMLT and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

Physician's Signature

Printed Name

Date Signed

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

Coverage will not be considered until this application is completed, signed and dated. Failure to provide complete information and/or attachments as requested will cause delay.

