HAPI

APPLICATION FOR MEMBERSHIP

IMPORTANT: If you are filling out this application online, you must use Adobe Reader.
Other applications such as Apple Preview will not work.

Application Checklist

The following documents will be used to process your application. Please submit the documents with your completed application.

- ☐ Current copy of your curriculum vitae (CV).
- ☐ Current copies of all office/practice letterhead stationery.
- ☐ Certificate of Insurance or Declaration Page from your current malpractice carrier.

Additional Reference Letter Policies

All applicants must submit at least two letters of reference in support of their application for membership. These letters of reference should be submitted directly to HAPI/PIP by the individual sending the letter. The letters must be on letterhead, have contact numbers and be signed. HAPI/PIP does not consider "form" letters of reference as adequate letters of reference. **Your application will be considered incomplete if appropriate letters of reference have not been received.**

Letters of reference should be from physicians who are able to comment on your competency, skills, medical practice and/or relationships with patients. Applicants who have completed a residency or fellowship within two (2) years of their application must have letters of reference submitted from their residency and/or fellowship program, one of which must be from the chief of service. All other applicants must have submitted letters of reference from physicians who are familiar with, or have observed, their work within previous five (5) years.

You should have letters of reference submitted by physicians who would not be viewed as unduly biased. To that end, HAPI/PIP requests that your letters of reference be submitted by persons other than those with whom you have a close personal or business relationship, such as family members or life partners, close personal friends and business partners or associates.

Complete this application for any practice for which you want coverage. Retain a copy of your completed application for your records.

Submit your completed application to:

HAPI
Membership Underwriting Department
735 Bishop Street, Ste 311
Honolulu, Hawaii 96813
Fax: 808-528-0123
Email: info@hapihawaii.com

If you have questions, call 808-538-1908

APPLICATION FOR MEMBERSHIP

Personal Information

Last Name ______________________ First Name ______________________ Middle Name ______________________ ☐ MD ☐ DO

Other Names Used (AKA) ______________________ Date of Birth ____/____/____ Place of Birth ______________________ ☐ Male ☐ Female

ECFMG No _____-______________ HI Medical License No ______________________

Specialty Information

Specialty: ____

Do you want professional liability coverage for this specialty? ☐ Yes ☐ No

ABMS Certified? ☐ Yes ☐ No

Do you have plans to complete your Boards? ☐ Yes ☐ No

If yes, when do you plan to take your exam? Oral ______________ Written______________

Subspecialty: ____

Do you want professional liability coverage for this subspecialty? ☐ Yes ☐ No

ABMS Certified? ☐ Yes ☐ No

Do you have plans to complete your Boards? ☐ Yes ☐ No

If yes, when do you plan to take your exam? Oral ______________ Written______________

Coverage and Referral Information

Requested Date of Coverage: _____/____/____

CURRENT CARRIER: ____

DO NOT CANCEL YOUR CURRENT INSURANCE UNTIL COVERAGE THROUGH HAPI/PIP BEGINS.

How did you first hear about HAPI/PIP?

☐ Member Physician (Name): ____

☐ Joining Member/Group (Name): ____

☐ Mail: Letter/Brochure ☐ Exhibit Attendance ☐ Advertisement ☐ Website

☐ Other: ____

APPLICATION FOR MEMBERSHIP

Addresses

Primary Office Address | City | State | Zip Code

Contact Person (Name/Title) | Primary Office Phone | Primary Office Fax

Secondary Office Address | City | State | Zip Code

Contact Person (Name/Title) | Secondary Office Phone | Secondary Office Fax

Pager Number | E-mail Address | Website Address

Home Address | City | State | Zip Code

Home Phone | Home Fax | Cell Phone | E-mail Address

Other Address | City | State | Zip Code

Temporary? ☐ Yes ☐ No If yes, until when? ____/____/____ Phone ____________________

Please indicate the appropriate address:

Primary Correspondence: ☐ Home ☐ Primary Office ☐ Secondary Office ☐ Other

Billing Address: ☐ Home ☐ Primary Office ☐ Secondary Office ☐ Other

Best phone number and/or e-mail address at which to contact you: ________________________________

Practice History

List all locations where you have practiced since residency. Begin with the most recent location (include military service).

☐ Solo ☐ Employee ☐ Group: Group Name: ________________________________

City ____________________ State _____ Country __________ From ___ / ___ To *Present*

☐ Solo ☐ Employee ☐ Group: Group Name: ________________________________

City ____________________ State _____ Country __________ From ___ / ___ To ___ / ___

☐ Solo ☐ Employee ☐ Group: Group Name: ________________________________

City ____________________ State _____ Country __________ From ___ / ___ To ___ / ___

☐ Solo ☐ Employee ☐ Group: Group Name: ________________________________

City ____________________ State _____ Country __________ From ___ / ___ To ___ / ___

Please explain all gaps in practice ________________________________

Training Information

Note: If the current CV you submitted with this application contains training information, you may skip this page.

Medical School: From: Mo_________ / Year _________ To: Mo_________ / Year _________

Name ____

City ______________________________ State _____ Zip Code __________ Country ______________

Internship: From: Mo_________ / Year _________ To: Mo_________ / Year _________

Name ____

City ______________________________ State _____ Zip Code __________ Country ______________

Residency: From: Mo_________ / Year _________ To: Mo_________ / Year _________

Name ____

City ______________________________ State _____ Zip Code __________ Country ______________

Residency: From: Mo_________ / Year _________ To: Mo_________ / Year _________

Name ____

City ______________________________ State _____ Zip Code __________ Country ______________

Fellowship: From: Mo_________ / Year _________ To: Mo_________ / Year _________

Name ____

City ______________________________ State _____ Zip Code __________ Country ______________

Other: From: Mo_________ / Year _________ To: Mo_________ / Year _________

Name ____

City ______________________________ State _____ Zip Code __________ Country ______________

APPLICATION FOR MEMBERSHIP

Practice Information

Please provide information on the practice for which you want coverage. For a new practice, please estimate.

Number of patients seen weekly: _______ Number of hours worked weekly: _______

Do you have medical professional liability coverage from another insurer for any part of your medical practice for which you are not requesting coverage from HAPI/PIP? ☐ Yes ☐ No

Have there been any recent changes in your practice, or do you expect a change soon? ☐ Yes ☐ No

If yes, please provide a brief description of this practice: ______________________________

With whom do you share call: ______________________________

Hospital Privileges

Hospitals and surgery centers where you currently practice (or are applying for privileges).	City	State	Status Active/Pending	Must Total 100%
			☐A ☐P	%
			☐A ☐P	%
			☐A ☐P	%
			☐A ☐P	%

Employees/Contracted Personnel (Independent Contractors)

State the number of personnel you employ and contract with and list them by name and position in the space below or in the Remarks Section on Page 8.

☐ Nurse Practitioner* #: ______ ☐ Physician Assistant* #: ______ ☐ Midwives*: #: ______

☐ Nurse Anesthetists* #: ______ ☐ Physicians/Surgeons* #: ______ ☐ Other: ____________ #: ______

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____

____

*Additional information required. Contact HAPI

Miscellaneous

Do you practice any of the following procedures: (check either Yes or No and explain if yes)

(a)	Yes____	No____	Acupuncture
(b)	Yes____	No____	Alternative Medicine
(c)	Yes____	No____	Anesthesia or Intravenous Analgesia (either caudal, epidural, spinal, inhalation, intravenous, or other in surgicenter or other non-hospital facility)
(d)	Yes____	No____	Chelation Therapy
(e)	Yes____	No____	Convulsive Shock Therapy
(f)	Yes____	No____	Cosmetic Surgery
(g)	Yes____	No____	Endoscopy (explain type & type of endoscope, rigid, flexible, and accessories)
(h)	Yes____	No____	Research – FDA approved
(i)	Yes____	No____	Research – Not FDA approved
(j)	Yes____	No____	Hypnosis
(k)	Yes____	No____	Laser: Surgery
(l)	Yes____	No____	Liposuction
(m)	Yes____	No____	Sex Change
(n)	Yes____	No____	Surgery Outside Specialty in Office Setting
(o)	Yes____	No____	Weight Reduction Control (by soliciting or advertising for weight control patients, receiving patients referred from weight control clinics, and/or administering, dispensing, or prescribing drugs for weight control.)

Explanation:

____

____

____

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____

____

Entity Information

Are you currently practicing with or are you joining an Entity? ☐ Yes ☐ No

If yes, please provide the name of the Entity and describe your affiliation: ______________________________

____

Status: ☐ Partner/Shareholder ☐ Employee ☐ Independent Contractor ☐ Office Sharing

Do you provide medical care, advice, or treatment to patients on behalf of any Entity? ☐ Yes ☐ No

"Entity" is defined as: Any Health Facility, medical sole proprietorship, medical partnership, medical corporation, medical group, medical clinic, unincorporated association of Heathcare Practitioners formed for the purpose of practicing medicine, and any other personal, professional or business enterprise with which the Member has any association or relationship.

If yes, please provide the names of all the Entities for which you provide professional services:

____

____

What is your role in the Entity(ies), e.g. owner, employee, independent contractor? ______________________

____

Do two or more physicians provide patient care on behalf of the Entity(ies)**? ☐ Yes ☐ No

Is the Entity(ies) a surgicenter, laboratory or other type of facility**? ☐ Yes ☐ No

If yes, what type? ____

Do you:

Provide facilities or equipment to direct Healthcare Practitioners? ☐ Yes ☐ No

Provide personnel or administrative services to direct Healthcare Practitioners? ☐ Yes ☐ No

Share or lease office space or share staff with direct Healthcare Practitioners? ☐ Yes ☐ No

Bill for any direct Healthcare Practitioners? ☐ Yes ☐ No

Please list any other known physicians and non-physician Healthcare Practitioners associated with this practice other than call coverage and locum tenens: ____

____

____

Professional Disclosure

Question	Yes	No
Have you ever had a report related to an adverse matter filed against you with the Department of Regulatory Agencies, Regulatory Industries Complaint Office (RICO), the Board of Medical Examiners or any other government agency?	☐ Yes	☐ No
Has any government agency ever investigated, suspended, revoked, or taken any other action against either your narcotics license or your license to practice medicine?	☐ Yes	☐ No
Have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it is probable and reasonable that knowledge of such use would influence a patient in such patient's decision to engage your professional services or caused you to seek medical advice or treatment?	☐ Yes	☐ No
Have you ever pleaded no contest to, or been convicted of, a crime other than a misdemeanor traffic violation?	☐ Yes	☐ No
Have you ever had privileges at any hospital or other healthcare institution reduced, revoked, restricted, suspended, modified, or refused (either voluntarily or involuntarily) or been placed under observation?	☐ Yes	☐ No
Have you ever been requested or required to take remedial courses by any hospital or other healthcare institution?	☐ Yes	☐ No
Have you ever had professional liability protection or medical malpractice insurance refused, declined, cancelled or accepted on special terms?	☐ Yes	☐ No

If you have answered "yes" to any of the above questions, please explain below.

Remarks Section

Please use this section for questions asked which need clarification. Use additional remarks field on page 13 if necessary. Also, please attach appropriate documentation (e.g., medical board action report, notice of cancellation).

____

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____

____

____

Insurance History

Current carrier:	Policy number:	Limits of liability (in millions): ☐ $1/3 ☐ $2/4 ☐ Other:___/___	From: ___/___/___ To: ___/___/___
Prior carrier:	Policy number:	Limits of liability (in millions): ☐ $1/3 ☐ $2/4 ☐ Other:___/___	From: ___/___/___ To: ___/___/___
Prior carrier:	Policy number:	Limits of liability (in millions): ☐ $1/3 ☐ $2/4 ☐ Other:___/___	From: ___/___/___ To: ___/___/___
List all periods you practiced without malpractice coverage: From: ___/___/___ To: ___/___/___ Reason: ___________________			

Claims History

Note: You must fully disclose all claims asserted and suits filed against you. Note carefully the broad definition of "claims" and respond completely and accurately to the questions asked in the application. "Claim" as used in this application is defined as follows:

(a) any contention that personal injury or damages have been or may have been sustained by any act, error or omission;

(b) any demand for money or other relief; or

(c) circumstances which have been brought to your attention by a patient or on behalf of a patient (including, without limitation, by the patient's attorney, other medical personnel treating the patient or any hospital personnel) or otherwise, indicating the possibility that personal injury or damages may have been sustained by any act, error, or omission arising out of or related to the rendition of or failure to render professional services by you, your corporation, your partnership, or any partner, associate or employee of yours or of any other person or entity with whom you now conduct or have conducted your professional practice, regardless of whether such contention resulted in the payment of any monies to or on behalf of the claimant.

Have you ever had a malpractice claim or lawsuit against you? ☐ Yes ☐ No

If yes, how many? _______________

If you have answered "yes" to the above, you must give full details on pages 14-15, of this application. Fill out the claim information for each claim, open or closed. You must submit any additional information requested relating to these claims in order for your application to be considered.

APPLICATION FOR MEMBERSHIP

Retroactive Coverage

By checking **"Yes"** below, you are applying for retroactive coverage. This coverage is also known as "prior acts" coverage or "nose" coverage. If you are not requesting retroactive coverage, please check **"No."**

If you are approved for retroactive coverage, you will receive a Certificate of Coverage with a specified Retroactive Date. Thereafter, you will be entitled to the medical professional liability coverage for any **unknown** incidents that may lead to a lawsuit or other Claim based on an Occurrence that takes place after the Retroactive Date so specified. Retroactive coverage is not available for any period during which you had no medical malpractice coverage or which you had occurrence-type coverage or which you provided professional services outside of Hawaii.

☐ **YES**, I hereby apply for retroactive coverage through HAPI/PIP for any unknown incidents that may lead to a lawsuit or other Claim based on an Occurrence in Hawaii that takes place on or after my Retroactive Date. I represent that I have and will continue to maintain uninterrupted claims-made professional liability coverage for all Professional Services rendered during the retroactive coverage period for which I am now seeking retroactive coverage through HAPI/PIP. I further represent that I will maintain my current professional liability coverage up to the Effective Date of coverage through HAPI/PIP

The retroactive coverage period will be determined from your current certificate of insurance or declaration page.

☐ **NO**, I decline retroactive coverage through HAPI/PIP.

Was tail coverage purchased? ☐ Yes ☐ No

If yes, please provide a copy of the tail coverage endorsement.

This Application for retroactive coverage is deemed part of your Application for Membership

By my signature on page 12 of this Application for Membership, I declare under penalty of perjury that the foregoing is true and correct.

References

Please provide names of two physicians familiar with your practice who we may contact.

Name	Specialty	City	State

Phone	Fax	E-mail

Name	Specialty	City	State

Phone	Fax	E-mail

Representations, References, Authorizations, Etc.

I have disclosed in this application complete and accurate information requested and all information which may reasonably influence PIP's decision to accept me as a member.

I understand and agree that, except as may be specifically provided in the PIP trust agreement, my membership in PIP will not cover the liability of other persons which I may have assumed under any other agreement.

I understand and agree that my execution of this application does not require PIP to admit me as a member in PIP nor does it require me to become a member of PIP if accepted. In addition, I understand and agree that I have no right to receive any information regarding the basis or reasons for any decision about my application. I further understand that my membership and my professional liability coverage does not become effective until my application has been accepted and my initial contribution has been paid.

I agree that no member of the peer review committee, claims review committee, the board of trustees or any other committee, or its members, shall be liable for action taken by the committee or the committee member in reviewing my qualifications to participate, or continue to participate, or to modify or restrict my ability to participate, or the quality of medical services rendered, or the validity of a medical malpractice claim, unless it is alleged and proven that such action was taken with actual malice.

I understand that in order to provide me with professional liability coverage, the physicians' indemnity plan must have reasonable access to all information concerning my professional life and such aspects of my personal life as may bear on my professional career. Therefore, I authorize and direct any government agency, medical society, physician, hospital, insurance company, underwriter, or insurance agent contacted by or on behalf of physicians' indemnity plan to furnish any information concerning me or my medical practice which physicians' indemnity plan may request. I also agree that any person or organization which furnishes information to physicians' indemnity plan pursuant to this authorization, together with the officers, directors, agents, and employees or such person or organization, will not be liable to me in any way for furnishing such information even though the information may be incomplete or incorrect.

Arbitration Clause

I agree that any dispute or controversy arising out of, in connection with or in relation to this application shall be submitted to, and determined and settled by arbitration in Honolulu, Hawaii, in accordance with the applicable rules of the American Arbitration Association in effect at the time demand for arbitration is filed. I further agree that any arbitrators selected shall be medical doctors and that reasonable attorney's fees and cost of such arbitration shall be awarded to the prevailing party. Any award rendered in such arbitration shall be final and binding on each of the parties hereto, and judgement thereon may be entered in any court of competent jurisdiction. This provision constitues a written agreement to submit to arbitration.

New Member Agreement

I acknowledge that I must attend a HAPI new member risk management meeting within one year of joining HAPI. If I fail to attend, my assessment may be adjusted upwards, at the discretion of the board of trustees. I understand that my submission of this application serves as my HAPI Membership Request.

By signature below, I verify that I read, understand, and agree to the foregoing.

Date:______________________ Signature:____________________________________

Additional Remarks

APPLICATION FOR MEMBERSHIP

CLAIM FORM

Please Submit as Many Claim Forms as Needed

1. Name of Patient: ______________________________

2. Age: __________ 3. ☐ Male ☐ Female

4. Your relationship to patient (e.g., attending physician, primary surgeon, asst. surgeon):

____

5. Date of Incident: ___/___/___ 6. Location: ______________________________

7. Insurance Carrier: ______________________________

8. Other Defendants: ______________________________

9. Current Status: ☐ Incident Only	☐ 90 Day Notice ☐ Suit Filed	☐ Suit Served ☐ Arbitration
☐ Open	Indemnity Reserve Amount: $______________	Expense Reserve Amount: $______________
☐ Closed	Date Closed: ____/____/____	
Method of Closing (if applicable)		
☐ Dismissed	☐ Defense Verdict	
☐ Settled:	Amount paid on your behalf: $______________	Total Settlement: $______________
☐ Judgment:	Amount paid on your behalf: $______________	Total Judgment: $______________

10. Patient's allegations or circumstances brought to your attention: ______________________________

____

11. Condition and diagnosis at time of incident: ______________________________

____

12. Dates and description of treatment rendered: ______________________________

____

13. Condition of patient after treatment (and dates of follow-up treatment): ______________________________

____

14. Describe the nature of the injuries your patient alleges were sustained: ______________________________

____

15. Please print your name: ______________________________

ADDITIONAL CLAIM FORM

Please Submit as Many Claim Forms as Needed

1. Name of Patient: ____

2. Age: __________ 3. ☐ Male ☐ Female

4. Your relationship to patient (e.g., attending physician, primary surgeon, asst. surgeon):

____

5. Date of Incident: ___/___/___ 6. Location: ______________________________

7. Insurance Carrier: ____

8. Other Defendants: ____

9. Current Status: ☐ Incident Only	☐ 90 Day Notice ☐ Suit Filed	☐ Suit Served ☐ Arbitration
☐ Open	Indemnity Reserve Amount: $_______________	Expense Reserve Amount: $_______________
☐ Closed	Date Closed: ____/____/____	
Method of Closing (if applicable)		
☐ Dismissed	☐ Defense Verdict	
☐ Settled:	Amount paid on your behalf: $_______________	Total Settlement: $_______________
☐ Judgment:	Amount paid on your behalf: $_______________	Total Judgment: $_______________

10. Patient's allegations or circumstances brought to your attention: ______________________________

____

11. Condition and diagnosis at time of incident: ______________________________

____

12. Dates and description of treatment rendered: ______________________________

____

13. Condition of patient after treatment (and dates of follow-up treatment): ______________________________

____

14. Describe the nature of the injuries your patient alleges were sustained: ______________________________

____

15. Please print your name: ____