



Locum Tenens Coverage Guidelines

CMIC's professional liability policy includes 45 days of Locum Tenens coverage per policy year at no additional cost. Locum Tenens coverage allows a physician to add another physician who is temporarily substituting for a covered physician while on vacation or unable to work due to illness, etc., as an additional insured on a member's policy. Locum Tenens coverage is only necessary when the substituting physician does not have his own professional liability insurance or has limited insurance that will not cover him for substituting activities. If a physician must use Locum Tenens coverage some guidelines about its use are listed below.

- Coverage is only provided for claims that arise out of medical services provided by the Locum Tenens physician on behalf of and in the absence of the CMIC insured member.
- The substituting physician must be licensed to practice medicine or osteopathy in the State of Connecticut and must be an acceptable underwriting candidate for CMIC.
- In order to request the coverage, **the substituting physician must complete a Locum Tenens application that must be received by CMIC prior to the date of substitution.** (Only one application per substituting physician per year is necessary.)
- It is the responsibility of the CMIC member to keep track of the date(s) substituted and the name of the Locum Tenens physician who substituted for him/her. CMIC reserves the right to audit such records.
- Locum Tenens physicians share in the CMIC insured's limits of liability. All policy terms and conditions remain the same.
- Locum Tenens days can be used in increments of full or half days. A half-day is defined as four hours or less; a full day is defined as up to 24 hours of continuous coverage. For example, a CMIC member signs out to his Locum Tenens physician at 8:00 pm on Friday night and resumes practice on Saturday at 8:00 pm. This would count as one "day" of Locum Tenens coverage.
- If the CMIC member cancels the policy and does not obtain an extended reporting period endorsement there will be no coverage for the member or the Locum Tenens physician for claims reported more than thirty days after the termination date of the policy.



Connecticut Medical Insurance Company

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(CT only) 800.228.0287
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(CT only) 800.403.3580

CMIC APPLICATION FOR ADDITIONAL INSURED - LOCUM TENENS COVERAGE

PO Box 71, Glastonbury, Connecticut 06033 860.633.7788 FAX 860.633.8237

A. CMIC Named Insured Information Section

- 1. Name of CMIC Insured:
2. Policy Number:
3. Signature
4. Date

B. Locum Tenens Applicant Information Section

If the application is approved and a CMIC member authorizes you to be endorsed on the policy, insurance will be afforded to the Locum Tenens physician to the named insured physician's professional liability insurance policy. Coverage for the Locum Tenens physician applies only for acts or omissions in providing professional services on behalf of and in the absence of the named insured. If the named insured's policy is cancelled and an additional Extended Reporting Period Endorsement is not obtained, coverage provided by the Locum Tenens Endorsement shall terminate as of the termination of the policy.

- 1. Name of Applicant:
2. Home Address (Street, City, State, Zip)
3. Business Address
4. Home Phone Number
5. Business Phone Number
6. Date of Birth
7. Social Security Number
8. Medical Specialty
9. Medical School (name & location)
10. CT Medical License Number
11. Narcotics License Number
12. Specialty Credential Status: Board Eligible, Board Certified, Other
12a. Name of Specialty Board
13. Are you currently enrolled in a residency program? Fellowship Program?
14. Are you currently: Retired? Employed by a hospital or other institution which provides professional liability coverage for you? Other?
15. Do you currently have an individual professional liability policy through CMIC or other insurance company?
16. Please attach a copy of your current Curriculum Vitae
17. Describe the duties you will perform as a locum tenens physician. Include any invasive procedures or procedures using contrast dye.

C. Claims Section (Please explain, on a separate sheet, a Yes answer.)

1. Has **any** claim or suit for alleged malpractice **EVER** been brought against you? Yes No

D. Underwriting Section (Please explain, on a separate sheet, any Yes answers.)

- 1. Has **any** hospital or other health care facility **ever** denied, suspended, non-renewed, revoked, declined or in any way restricted your privileges or has probation **ever** been invoked? Yes No
- 2. Have you **ever** voluntarily agreed to surrender your hospital or other health care facility privileges? Yes No
- 3. Have you **ever** voluntarily agreed to modify your hospital or other health care facility privileges? Yes No
- 4. Has your medical license **ever** been suspended, revoked, voluntarily surrendered or has probation or any limitations **ever** been invoked? Yes No
- 5. Has your narcotics license **ever** been suspended, revoked, voluntarily surrendered or has probation or any limitations **ever** been invoked? Yes No
- 6. Have you **ever** signed a consent order or a consent agreement with a state health department, state licensing board or other governmental body? Yes No
- 7. Have you **ever** been investigated by a state health department, state licensing board or other governmental body? Yes No
- 8. Have any complaints **ever** been registered against you with any employer, medical association/ society, specialty board, hospital or other health care facility or state licensing authority or other governmental body? Yes No
- 9. Have you **ever** been denied certification by a specialty board? Yes No
- 10. Has any insurance company **ever** cancelled, non-renewed, denied you professional liability insurance or offered you professional liability insurance only on special or restricted terms? Yes No
- 11. Have you **ever** been arrested for any criminal offense in the past 10 years **excluding** misdemeanors? Yes No
- 12. Are any of the actions in Items 1-11 above currently under investigation? Yes No
- 13. Do you now or have you **ever** had any defect, illness or disorder, whether physical, mental or emotional, that limits or impairs, has limited or impaired or **COULD** limit or impair your ability to practice to any degree? Yes No
- 14. Do you now or have you **ever** had a drug or alcohol addiction or dependency? Yes No

Please read the following carefully, then sign and date the application in the space provided below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. **I AGREE** to notify the Connecticut Medical Insurance Company (the "Company") promptly of any material changes in the information I have provided herein. **I UNDERSTAND** that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

DISCLOSURE AUTHORIZATION

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record of knowledge concerning any of the statements and answers made by me herein to release such information the Connecticut Medical Insurance Company ("Company") and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues. **I AUTHORIZE** the Company and such representatives to use a copy of this authorization in place of the original.

This authorization shall be valid for the period during which I am insured by or am seeking insurance from the Company. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

Signature - Locum Tenens Applicant

Date

Underwriting Approval
1/21/2004

Date