

**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 copy Hawaii Medical License.
- 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: HAPI@hapihawaii.com

**If you have questions, call 808-538-1908**



# APPLICATION FOR MEMBERSHIP

## Personal Information

Last Name	First Name	Middle Name	<input type="checkbox"/> MD
_____	_____	_____	<input type="checkbox"/> DO
Other Names Used (AKA)	Date of Birth	Place of Birth	<input type="checkbox"/> Male
_____	____/____/____	_____	<input type="checkbox"/> 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%
			<input type="checkbox"/> A <input type="checkbox"/> P	%
			<input type="checkbox"/> A <input type="checkbox"/> P	%
			<input type="checkbox"/> A <input type="checkbox"/> P	%
			<input type="checkbox"/> A <input type="checkbox"/> 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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# APPLICATION FOR MEMBERSHIP

## 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 Healthcare 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**

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever pleaded no contest to, or been convicted of, a crime other than a minor traffic violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 subject to monitoring not routinely applied to other practitioners of your specialty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been requested or required to take remedial courses by any hospital or other healthcare institution?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had professional liability protection or medical malpractice insurance refused, declined, cancelled or accepted on special terms?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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): <input type="checkbox"/> \$1/3 <input type="checkbox"/> \$2/4 <input type="checkbox"/> Other:___/___	From: ___/___/___ To: ___/___/___
Prior carrier:	Policy number:	Limits of liability (in millions): <input type="checkbox"/> \$1/3 <input type="checkbox"/> \$2/4 <input type="checkbox"/> Other:___/___	From: ___/___/___ To: ___/___/___
Prior carrier:	Policy number:	Limits of liability (in millions): <input type="checkbox"/> \$1/3 <input type="checkbox"/> \$2/4 <input type="checkbox"/> 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.



**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 constitutes 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: \_\_\_\_\_





**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: <input type="checkbox"/> Incident Only	<input type="checkbox"/> 90 Day Notice <input type="checkbox"/> Suit Filed	<input type="checkbox"/> Suit Served <input type="checkbox"/> Arbitration
<input type="checkbox"/> Open	Indemnity Reserve Amount: \$ _____	Expense Reserve Amount: \$ _____
<input type="checkbox"/> Closed	Date Closed: ___/___/___	
Method of Closing (if applicable)		
<input type="checkbox"/> Dismissed	<input type="checkbox"/> Defense Verdict	
<input type="checkbox"/> Settled:	Amount paid on your behalf: \$ _____	Total Settlement: \$ _____
<input type="checkbox"/> 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: \_\_\_\_\_



APPLICATION FOR MEMBERSHIP  
**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: <input type="checkbox"/> Incident Only	<input type="checkbox"/> 90 Day Notice <input type="checkbox"/> Suit Filed	<input type="checkbox"/> Suit Served <input type="checkbox"/> Arbitration
<input type="checkbox"/> Open	Indemnity Reserve Amount: \$ _____	Expense Reserve Amount: \$ _____
<input type="checkbox"/> Closed	Date Closed: ___/___/___	
Method of Closing (if applicable)		
<input type="checkbox"/> Dismissed	<input type="checkbox"/> Defense Verdict	
<input type="checkbox"/> Settled:	Amount paid on your behalf: \$ _____	Total Settlement: \$ _____
<input type="checkbox"/> 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: \_\_\_\_\_