ADMIRAL INSURANCE COMPANY 6455 East Johns Crossing, Suite 240 Duluth, GA 30097 Phone: 770-476-1561 — Fax: 770-418-9597 Internet: http://www.admiralins.com	PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION (CLAIMS-MADE FORM)

1. Full name of applicant: ______________________________

2. Principal office address: ______________________________
(If practicing at more than one location, attach a list of each additional office)

3. Home address: ______________________________

4. Social Security #: ________/________/________ DEA#: ______________________________

5. Date of Birth: ________/________/________ Place of Birth: ______________________________

6. Are you an U.S. Citizen? ______YES ______NO. If no, please indicate your status and date of entry into the United States:
____

7. I practice as:
______ Solo Practitioner (unincorporated)
______ Solo Practitioner (incorporated)
______ Professional Association
______ Employee
______ Partnership
______ Professional Corporation

8. Give the formal corporation, association, partnership or business name of the organization you work for and attach a copy of their letterhead: ______________________________

9. Do you own (wholly or in part) this entity? ______YES ______NO. If yes, are you seeking coverage for the entity as well as your own Medical Malpractice Insurance? ______YES ______NO. If yes, complete a separate Medical Professional Liability application for this entity.

10. If no to question 9, does this entity have an individual Medical Malpractice policy? ______YES ______NO. If yes, complete the following:

Carrier	**Limit**	**Premium**	**Policy Period**	**Retroactive Date**
______	______	______	______	______

Are employees other than physicians or surgeons covered? ______YES ______NO

11. List the names of all your partners, employees or members of your professional association or corporation who practice medicine:
____
____
____

12. Are all medical professionals required to carry their own individual Medical Malpractice Insurance? ______YES ______NO. If yes, what limits: ______________________. If no, what type(s) of medical professional(s) is/are not required to carry their own Medical Malpractice Insurance? ______________________________
____

13. List the license(s) number(s) and State(s) in which you practice: ______________________________
____

14. List the hospitals at which you are currently a member: ______________________________
____

15. Briefly describe the type and extent of your hospital privileges: ____
____
____

16. Are you the Chief or Head of a hospital department? ______YES ______NO. If yes, which department(s): ______________
____

17. From what Medical School did you graduate?

Name of Medical School: ______________________________

City, State and Country of Medical School: ______________________________

Type of Degree: ______________________________

Year of Graduation: ______________________________

If you received you medical degree from a foreign country, are you certified by the United States Educational Council for Medical School Graduates? ______YES ______NO. If yes, state the certification year: ______________________

18. Did you complete an Internship? ______YES ______NO. If yes, complete the following:

Location: ______________________________ Dates From: ______________ To: ______________
Type: ______________________________ Completed: ______ YES ______NO

19. Did you complete your Residency? ______YES ______NO. If yes, complete the following for each:

Location: ______________________________ Dates From: ______________ To: ______________
Type: ______________________________ Completed: ______ YES ______NO
Location: ______________________________ Dates From: ______________ To: ______________
Type: ______________________________ Completed: ______ YES ______NO

20. Additional Medical Training? ______YES ______NO. If yes, please provide details regarding type, location and dates.

Additional Medical Training:

____
____
____
____
____

21. Have you participated in any continuing medical education program(s) within the past five years? ______YES ______NO. If yes, please provide details regarding type, location and dates.

Medical Education Programs:

____
____
____
____
____

22. Indicate memberships in professional societies: ____
____
____

23. What is your medical or surgical specialty: ____

24. What is your sub-specialty: ____________________

25. Do you limit your practice to the above specialties? ______YES ______NO. If yes, what percentage of your practice is dedicated to each specialty: ____________________

26. Do you perform one or more of the following:

		YES	NO
A.	Endoscopic procedures other than sigmoidoscopy or proctoscopy. If yes, please describe: ____________________	______	______
B.	Catheterization other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel. If yes, please describe: ____________________	______	______
C.	Arteriography, lymphangiography, myelography or phenmoencephalography:	______	______
D.	Interventional radiology-percutaneous transluminal angioplasty or embolization.	______	______
E.	Radiation therapy including radium implants. If yes, please describe: ____________________	______	______
F.	Chemobrasion or dermabrasion:	______	______
G.	Hair transplantation or suturing of hairpieces:	______	______
H.	Mohs micrographic surgery. If yes, please describe: ____________________	______	______
I.	Acupuncture. If yes, please describe: ____________________	______	______
J.	Prenatal care and normal deliveries. If yes, indicate any of the following that apply:	______	______
	Do you perform home deliveries?	______	______
	Do you only perform prenatal care?	______	______
	Do you supervise nurse midwives? If yes, when do you refer: ________ weeks gestation.	______	______
K.	Dilation and curettage:	______	______
L.	Needle biopsies. If yes, please describe: ____________________	______	______
M.	Electroschock therapy or hypnosis. If yes, please describe: ____________________	______	______
N.	Radial keratotomy, excimer laser PRK, LASIK or any other surgical vision correction procedure. If yes, where is the procedure performed: Office______ Hospital ______ Surgicenter ______	______	______
O.	Surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia.	______	______
P.	Non-spontaneous, induced abortions. If yes, what trimester: ____________________. Where is the procedure performed: Office______ Hospital ______ Surgicenter ______	______	______
Q.	Vasectomies or reversal of vasectomies:	______	______
R.	Hysterectomies. If yes, do you perform laparoscopic hysterectomies?	______	______
S.	Cholecystectomies. I yes, do you perform laparoscopic cholecystectomies and how many performed to date? ____________________.	______	______
T.	Tonsillectomies and/or adenoidectomies	______	______
U.	Caesarian sections:		
V.	Spinal surgery. If you also perform chemonucleolysis, check here: ______ and/or percutaneous lumbar disectomy, check here: ______	______	______
W.	Administration of general, spinal or caudal block anesthesia:	______	______

X. Open reduction of fractures. If yes, please describe:________________________________ ___________ ___________
____

Y. Organ transplantation. If yes, please describe: _____________________________________ ___________ ___________
____

Z. Sex change operations: ___________ ___________

AA. Weight Reduction Surgery. If yes, which procedure: ______________________________. ___________ ___________
What date was the first procedure performed on: ______/______/______. How many procedures performed to date: __________________________.

BB. Experimental research, surgical research or experimental therapy in human patients. If yes, please describe: ____ ___________ ___________

CC. Cosmetic/plastic surgery. If yes, complete the following: ___________ ___________
Do you perform breast augmentations? ___________ ___________
Do you perform breast reductions? ___________ ___________
Do you perform liposuction. If yes, what is the maximum amount of cc's removed? ____ ___________ ___________
Do you perform fat recycling? If yes, in which parts of the body?: __________________ ___________ ___________
Do you perform phallaplasty? ___________ ___________
Do you perform vaginoplasty or labiaplasty? ___________ ___________
Do you use silicone implants? If yes, in which parts of the body: ___________________ ___________ ___________
Do you perform botox injections? ___________ ___________

DD. Any other surgery. If yes, please describe: _______________________________________ ___________ ___________
____

27. Do you perform surgery in your office? ______YES ______NO. If yes, please list the surgical procedure(s): ________________
____

28. Do you perform surgery in other non-hospital facilities? ______YES ______NO. If yes, list the type of facility and surgeries performed: ____
____

29. In the course of surgery, who administers general anesthesia? ____

30. Do you do any hospital emergency room work? ______YES ______NO. If yes, please answer the following questions. Is the emergency room care:
Only on your own patients? ______YES ______NO.
Required for staff privileges? ______YES ______NO. Other: ____

31. Do you assist in surgery on you own patients? ______YES ______NO. On patients of others? ______YES ______NO.

32. If your practice includes plastic surgery, specify the percentage of your practice devoted to:
______% Traumatic surgery ______% Cosmetic surgery

33. If your practice includes weight reduction or control (other than by diet and exercise), specify the percentage of patients that are exclusively weight control: ______%. Do you dispense (as opposed to prescribe) any weight control drugs? ______YES ______NO. If yes, please list the type(s) of drugs dispensed: ____
____
Do you use injection for weight control? ______YES ______NO. If yes, list the type(s) of drugs injected

34. List the number and type of professionals you employ. (Do not include independent contractors):

Type of Professional	# Employed	Description of duties and extent of supervision
______Physicians (other than yourself)	___________	______________________________
______Physician's Assistant	___________	______________________________
______Surgeon's Assistant	___________	______________________________
______Nurse Practitioner	___________	______________________________
______Nurse Anesthetist	___________	______________________________
______Other, please describe: ____________________	___________	______________________________
______________________________________		

35. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ______YES ______NO. If no, attach explanation.

36. Have you or any of the above employees:

	YES	NO
A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? Attach a copy of Complaint and Consent Order document if applicable.	___________	___________
B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses.	___________	___________
C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction?	___________	___________
D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	___________	___________
E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?	___________	___________
F. Ever failed any medical licensing or specialty organization examination?	___________	___________
G. Do you have any chronic illnesses or defects?	___________	___________

37. Do you supervise any individuals other than your own employees? ______YES ______NO. If yes, how many and what type of employee(s):

Type of Professional	YES	NO	# Supervised
Physicians	_____	_____	_________
X-Ray Technicians	_____	_____	_________
Laboratory Technicians	_____	_____	_________
Other:	_____	_____	_________
____________________			

Provide a detailed explanation of your responsibilities and relationship to the entity that employs these individuals:
____
____
____

38. Are you in the employ of any individual, firm or corporation other than your own? ______YES ______NO. If yes, attach an explanation including details of responsibilities.

39. Are you under contract to any individual, firm or corporation other than your own? ______YES ______NO. If yes, attach an explanation including details of responsibilities. If this contract contains a "hold harmless" agreement then attach a copy of the contract language.

40. Are you in the employ of or under contract with any governmental entity? ______YES ______NO. If yes, attach an explanation including details of responsibilities.

41. Are you American Board certified? ______YES ______NO.
Medical specialty: ______________________________________ Date certified: _________/_________/_________

42. Where have you practiced your profession since completion of training:
In: ______________________________________ From:_______________ To: _______________
In: ______________________________________ From:_______________ To: _______________
In: ______________________________________ From:_______________ To: _______________

43. Do you participate in any activity (e.g.; newspaper columns, broadcast, etc.) whereby professional advice is offered to the public? ______YES ______NO. If yes, attach a detailed explanation.

44. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? ______YES ______NO. If yes, attach a copy of advertisement.

45. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? ______YES ______NO. If yes, attach a copy of advertisement.

46. Do you practice in a surgicenter, abortion clinic, drug control clinic, urgent care clinic, walk-in clinic or birthing center? ______YES ______NO. If yes, please state and describe location: ______________________________________
____

47. Average weekly patient load: ______________________ Total patients annually: ______________________
Average number of surgeries performed per week: ______________________
Total surgeries performed annually: ______________________

48. Average number of hours worked per week: ______________________

49. Do you anticipate any changes in your practice? ______YES ______NO. If yes, please describe: ______________________
____

50. Indicate the approximate gross annual income from your practice: $______________________

51. List the prior Medical Malpractice Insurance carried for each of the past 5 years:

Carrier	Limit	Premium	Policy Period	Retroactive Date

ATTACH A COPY OF THE DECLARATIONS PAGE OF YOUR MOST RECENT POLICY. NOTE: FOR EACH CLAIM, PLEASE COMPLETE THE SUPPLEMENTAL CLAIM INFORATION FORM.

52. Do you or the firm named in Question 8 own, operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? ______YES ______NO. If yes, please describe: _______________
____

53. Has any claim or suit for alleged malpractice been brought against you? ______YES ______NO. If yes, how many total claims or incidents: ______________________

54. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? ______YES ______NO.

55. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suite being made or brought against you? ______YES ______NO.

WARRENTY: It is warranted to Admiral Insurance Company that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein should the Company evidence its acceptance of the application by issuance of a policy. I/we hereby authorize the release of claim information from any prior insurer to Admiral Insurance Company.

PLEASE REVIEW THE POLICY CAREFULLY: Except to such extent as may be provided otherwise in the policy, the policy for which this application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force.

____ ____
Date: Signature of applicant

ONE SIGNED COPY WILL BE ATTACHED TO THE POLICY, COVER NOTE OR CERTIFICATE, IF ISSUED. SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. APPLICATION MUST BE CURRENTLY SIGNED AND DATED TO BE CONSIDERED FOR QUOTATION.