Submitted by:
Agency: _____

Address: _____

City _____ State_____ Zip _____

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS

THIS IS FOR A CLAIMS MADE AND ASSERTED POLICY

APPLICANT'S INSTRUCTIONS:

1. If you have a Curriculum Vitae (resume) please attach it to the application and check here_____ .
2. Answer all questions; If a question is not applicable, state "NOT APPLICABLE"
3. If Space is insufficient to answer any questions fully, attach a separate sheet.
4. The Application must be signed and dated by the applicant.
5. It the answer to any question is none, state "NONE".
6. Please do not complete the application earlier than 45 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT IN INK)

1. A. Full Name of Individual Applicant: (Include professional degree)

_____ degree:_____

B. Date of Birth_____ Place of Birth_____

C. Are you a U. S. Citizen? ____ If "no" please indicate your status and entry into USA on separate sheet. Include a copy of your current Permanent Visa

2. A. Principal Office:_____
No. Street City County State Zip

Phone # _____

B. Other Offices (if any)_____

Phone: _____

_____

Phone: _____

3. A. Limits of Liability desired: _____
(Limits in policy will govern coverage)

4. Desired Effective Date (12:01 a.m.): _____

5. I practice as: _____ Solo Practitioner (unincorporated) _____ Professional Corporation
_____ solo Practitioner (incorporated) _____ Partnership
_____ Employee of (name:) _____ _____ Professional Corporation

_____ Other (Describe)_____

6. If you practice other than as an employee or an unincorporated solo practitioner:

A. List the names of ALL your partners, your employees or members of your professional association or corporation who practice medicine and their current insurance carriers:

_____
_____
_____
_____
_____

B. Provide the formal corporate, association, partnership or business name:

_____

C. Attach a copy of your letterhead

7. List all states where you are licensed to practice:

_____ Permanent or Temporary? _____

_____ Permanent or Temporary? _____

_____ Permanent or Temporary? _____

Other States (if any) -_____ _____

8. A. List hospitals at which you are currently a staff member and show % of work at each hospital.

_____ %ge _____

_____ %ge _____

_____ %ge _____

_____ %ge _____

B. Briefly describe type and extent of your hospital privileges:

_____
_____
_____

Permanent _____ Temporary Permanent _____ Temporary

C. Are you Chief or Head of a hospital department? _____ Yes _____ No

9. Do you or the firm listed in Question 6.B. above own (wholly or in part), operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? _____

If "yes" provide details, including name, location, size and number of beds.

CURRENT PRACTICE

10. A. What is your medical or surgical specialty? _____
    B. Do you limit your practice to the above specialty? _____
    If no, then explain (include detail on all sub-specialties)
    _____
    _____
    _____

11. Do you perform one or more of the following:
    A. Endoscopic procedures (other than sigmoidoscopy or proctoscopy)? _____
    If "yes" describe
    _____
    _____

    B. Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel)? _____
    If "yes" describe: _____
    _____

    C. Arteriography / lymphangiography / myelography / pneumoencephalography? _____

    D. Interventional radiology-percutaneous transluminal angioplasty or embolizalion? _____

    E. Radiation therapy~deep (includes radium implants)? _____

    F. Chemobrasion / dermabrasion / hair transplants or suturing of hairpieces?

    G. Mohs micrographic surgery? _____ If "yes" describe: _____

    _____

    H. Acupuncture (for analgesia) or Acupuncture anesthesia? _____ If "yes" describe:
    _____
    _____

    I. Pre-natal care and normal deliveries? _____

    J. Episiotomies? _____

    K. Managing Toxemia? _____

    L. Low Forceps? _____

    M. Cesarean Sections? _____

    N. Mid Forceps? _____

    O. Amniocentesis in the third trimester? _____

    P. Breech Delivery

    Q. Dilation and curatage?

    R. Needle biopsies? Describe: _____

    S. Electroshock therapy or hypnosis? _____ if "yes" describe: _____
    _____

T. Radial keratotomy&/or Laser surgery? _____ if "yes" indicate where performed
_____Hospital
_____Office
_____Surgi~center

U. Experimental procedures or research or drug testing? _____ If "yes" describe in detail with attachments, if appropriate _____
_____
_____
_____
_____
_____

12. Do you perform any one or more of the following:

A. Surgery other than incision of boils and superficial abscesses or suturing skin and superficial facia? ____

B. Sterilization procedures? _____ if "yes" describe: _____
_____

C. Cosmetic plastic surgery, cosmetic body contouring (suction lipectomy), implantations, injections and/or blepharopigmentation? Describe: _____

Please also complete Cosmetic Surgery supplement to this application.

D. Spinal surgery or chemonucleolysis? _____

E. Open reduction of fractures? If so, describe: _____

F. Administration of general spinal or caudal block anesthesia? _____

G. Vaginal Hysterectomies _____

H. Abdominal Hysterectomies? _____

I. Office Gynecology? _____

J. Endometrial biopsy? _____

K. Cervical Biopsy? _____

L. Cervical Cautery? _____

M. Culdocentesis? _____

N. Cold Conization Cervix? _____

O. Tubal Litigation? _____

P. Salpingectomy? _____

Q. Oophorectomy? _____

R. A&P Repair _____

S. Ectopic Pregnancy? _____

T. Laparoscopy? _____

U. Tonsillectomies and/or Adenoidectomies? _____

V. Organ Transplantations? _____ if "yes" describe _____
_____
_____

W. Weight reduction surgery? _____

X Sex change operations? _____ if "yes" describe _____
_____
_____

Y. Experimental surgery or surgical research? _____ if "yes" describe _____
_____
_____

Z. Other surgery? _____ if "yes" describe _____
_____
_____

13. A. Do you employ, contract with or cover midwives? _____

B. Do you perform home or non~hospital deliveries? _____ if "yes" explain _____
_____
_____

C. Do you perform surgery in your office? _____ if "yes" list surgical procedures: _____
_____
_____

D. Do you perform surgery in other non-hospital facilities? _____ if "yes" list facilities and surgical procedures. _____
_____
_____

E. Do you perform therapeutic abortions in the first trimester? ____

F. Do you perform therapeutic abortions after 12 weeks?

G. Total number of abortions performed monthly on your patients _____

H. Total number of abortions performed monthly on other patients. _____

I. List hospitals, clinics or other facilities where you perform abortions _____
_____

J. In course of surgery (described in A or B above) is general anesthesia administered
   1. By you? _____
   2. By others? _____

14. A1. Indicate number of hours per month devoted to hospital emergency room care: _____
A2 How many patient do you see each month?: _____

B. Is this emergency room care:
   1. On your own patients only? _____
   2. Required for staff privileges? _____
   3. Other (detail) _____ _____

15. Do you assist in surgery:

A. On you own patients? _____

B. Patient of others? _____

16. If your practice includes plastic surgery, specify percent of practice devoted to:

traumatic surgery_____%

cosmetic surgery_____%

17. Do you practice weight reduction or control (other than by diet-exercise)? _____
If "yes" what percent of patients are exclusively weight control? _____%

Do you dispense (as opposed to proscribe) any weight control drugs? _____
If "yes" list drugs dispensed . _____

Do you use injections for weight control? _____ If "yes" list drugs injected _____
_____

18. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? _____ If "yes" please attach detailed explanation of this activity.

19. A. List number and type of professional employees: IN NONE, STATE NONE

_____ Physicians (other than yourself) _____ Surgeons Assistants
_____Nurse Practitioners _____ Physicians Assistants
_____Nurse Midwives _____ Nurse Anesthetists
_____Other (describe with duties in detail, including extent supervised on a separate sheet and attach)

B. Are all of the above individuals licensed in accordance with applicable state and federal regulations? _____ If "no", attach explanation.

20. ATTACH DETAILED EXPLANATION for ANY 'YES'. ANSWERS:

Have you or any of the above employees..

A Ever been the subject of investigation or disciplinary proceedings or reprimand by a governmental or administrative agency hospital or professional association? _____

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? _____

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 insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?

F. Ever failed any medical licensing or specialty organization examination?

G. Have any chronic physical illness or defect?

21. Do you supervise any individuals other than your own employees? _____ If "yes" provide a detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also indicate, by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

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

23. Are you under contract to any individual, firm or corporation other than your own? _____
If yes, attach explanation including details of your responsibilities. If this contract contains a hold-harmless agreement. copy of contract must be attached to the application.

24. Are you in the employ of any governmental entity? _____
If yes, attach explanation, including details of your responsibilities.

25. Are you under contract to any government entity? _____
If yes. attach explanation. including details of your responsibilities.

26. A. Do you advertise your professional services in any manner (other than a simple listing in the telephone directory)? _____
B. Are you associated with any agency or organization that engages in any kind of advertising for solicitation of patients? _____ If 'yes' submit copy of ALL the advertisements.

27. A. From what medical school did you graduate? _____
Degree: _____ Year: _____
Location of Medical School (City, State, County) _____

B. If foreign medical student graduate, are you certified by the Educational Council for Medical school Graduates? _____ If "yes". state year and describe _____
_____

C. Residency? Yes _____ If "yes" complete the following for each residency served:

Location _____ From _____ To _____
Type_____ Did you complete?_____

Location _____ From _____ To _____
Type_____ Did you complete?_____

Location _____ From _____ To _____
Type_____ Did you complete?_____

D. Additional Medical Training? _____ If "yes" complete the following:
Location _____ From _____ To _____ Type _____

E. Are you American Board certified? ____
If so what is your Specialty_____ Date certified: _____
Date Recertified:_____

28. Where have you practiced your profession since completion of training?
In_____ From _____ To _____
In_____ From _____ To _____
In_____ From _____ To _____
In_____ From _____ To _____

29. Indicate membership in professional societies:

A. American Board in Medical Specialties: _____
B. Special Medical Societies: _____
C. Specialty Colleges:_____
D. County Medical and Others: _____

30. Have you participated in any continuing medical education program within the past five years? _____
If yes, describe (include photocopies of CME certificates)_____

31. Do you or the firm named in Question 6. B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? _____
If yes, describe_____

32. Has any claim or suit for alleged malpractice been brought against you? _____
If "yes" a Supplemental Claim Information Form. must be completed for each claim or suit.

33. Has any judgment been rendered against you or any monetary settlement made by you or on your behalf by any Insurance carrier, from an incident alleging malpractice? _____
If "yes" a Supplemental Claim Information Form. must be completed for each claim or suit.

34. ARE YOU AWARE OF ANY ACTS, ERRORS, OMISSIONS OR CIRCUMSTANCES WHICH MAY RESULT IN A MALPRACTICE CLAIM OR SUIT BEING MADE OR BROUGHT AGAINST YOU?
_____
IF "YES" A SUPPLEMENTAL CLAIM INFORMATION FORM MUST BE COMPLETED FOR INCIDENT

35. Do you practice in a surgi-center. abortion clinic, drug control clinic, emergi-center, extended hours walk-in clinic or birthing center? _____ If "yes.", state location and describe:_____

36. A. Average patient load: _____ Pts. weekly _____ Total Pts Annually

B. Average number of hours practice time; _____ Hrs. Weekly

37. List prior professional liability insurance carried for each of the past ten years. IF NONE, STATE NONE.

Insurer	Policy #	Policy Limit	Deductible	Premium	Inception	Expiration

38. What is the retroactive exclusion date on your current policy? _____

WARRANTY; It is warranted to the Insurer 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 the Insurer and to the Underwriting Manager for the Insurer.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force. Furthermore the policy includes the cost of defense of claims within the policy limit which means that the Policy limit available to pay a claimant WILL be reduced by the cost of investigation, defense and other expenses involved in the defense. The applicant, by signing this application below confirms (his/her) understanding of all provisions represented by the Insurer.

Signature of Applicant_____Date_____

One signed copy will be attached to the policy cover note or certificate if issued.

[4]SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE INSURER OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE.

Application MUST be currently signed and dated to be considered for quotation.

APPLICATION FOR PRIOR ACTS COVERAGE
(MUST BE RETURNED WITH THE PROFESSIONAL LIABILITY APPLICATION)

PLEASE PRINT OR TYPE

Item 1. Name of Applicant: _____

Item 2. Earliest Date of Prior Acts Coverage Requested: _____

At all times, from the date above, have you been continuously covered by a claims-made policy? _____

If "No", please explain: _____

_____

Item 3. In the last 24 months, (or if date of retro is more than 24 months) do you have knowledge of the following:

If any answers to the following questions are affirmative, please submit detailed information on a separate sheet of paper to include the following:

Patient's Name
Date(s) of Treatment in question
Outcome/Result

I. All Physicians (must complete)

	Yes	No
A. Any patient(s) who had an injury resulting from your treatment?		
B. Any patient(s) who had any unexpected compromise to airway or neurovascular bundle that led to injury?		
C. Any patient(s) who had a poor result that was not expected and became angry at you?		
D. Any patient(s) who died unexpectedly while under your care?		
E. Any patient(s) who had unexpected respiratory or cardiac arrest?		
F. Any patient(s) who sustained a major organ failure (heart, lung or kidney) not present at time treatment was rendered?		
G. Any case(s) where a foreign body was retained?		
H. Any written or verbal contact from patient, family, attorney or other representative with a demand for money or services or other indication of an intent to file a claim, lawsuit or other complaint against you?		

II. Surgeons - All

	Yes	No
A. Unexpectedly returned to the operating room during the same admission?		
B. Sustained an acute MI or CVA during or within 72 hours of elective surgery or other major diagnostic or therapeutic procedure?		
C. Patient with post operative course that led to permanent injury?		

III. Neurosurgeons and Orthopedic Surgeons

	Yes	No
A. Have you ever performed "pedicle screw" procedures?		
Do you currently do "pedicle screw" procedures?		
Approximate number per year: _____		
Have you ever used the "pedicle screw" for procedures <u>not</u> formally approved by the FDA?		

IV. Obstetrics

	Yes	No
A. Any result that led to injury of the mother?		
B. Any result that led to injury of the infant?		
C. Specifically:		
Cerebral palsy?		
Mental retardation?		
Fractures?		
Brachial plexus?		
DEATH(S)?		

Item 4: Has your practice changed in any way since the date noted in Item 2 (classification or procedure changes)?

If "yes", please specify: _____

Item 5: ATTACHED A COPY OF THE MOST RECENT CLAIMS-MADE POLICY ISSUED TO YOU. This must contain the retroactive date noted in Item 2 above. If it does not, attach all policies pertaining to the continuous claims-made coverage which you have had back to the date stated in Item 2.

Item 6: If you require coverage for "Additional Insureds" that were on prior policies, you must include any endorsements showing the type and name of those Additional Insureds. This includes group coverage. Each proposed Additional Insured is subject to a separate underwriting decision.

If the limits of liability under your prior claims-made policy was less than that for which you are applying for hereunder, the lower limits applies.

Please understand that there may be differences in coverage between that provided by your previous carrier(s) and the coverage applied for hereunder. Only those items covered under the Policy will be covered under a prior acts endorsement.

I declare that I know of no potential or actual claims, suits or incidents presently pending which have not been reported to my previous carrier(s). I understand that "Carrier" also means "Insurer".

I understand that this is only an application for Prior Acts Coverage and not a guarantee of coverage. **UNDER NO CONDITION WILL PRIOR ACTS BE COVERED WITHOUT THE RETURN OF THIS APPLICATION AND A PROPERLY EXECUTED ENDORSEMENT.**

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT IF PRIOR ACTS COVERAGE IS OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION, IT IS VOID.

I FURTHER WARRANT THAT I HAVE LISTED ALL INCIDENTS, AND UNFAVORABLE OR ADVERSE RESULTS KNOWN TO ME, OR OF WHICH I SHOULD HAVE BEEN AWARE, WHICH WOULD ARISE FROM MY ACTS OR OMISSIONS WHICH HAVE OCCURRED WITHIN THE LAST TWENTY-FOUR (24) MONTHS, OR SINCE THE REQUESTED RETROACTIVE DATE, IF MORE THAN TWENTY-FOUR MONTHS. I FURTHER WARRANT THAT I HAVE NOT WITHHELD ANY INFORMATION THAT IS REASONABLY LIKELY TO INFLUENCE THE JUDGMENT OF THE COMPANY IN CONSIDERING MY REQUEST FOR PRIOR ACTS COVERAGE. I FULLY UNDERSTAND THAT ANY INCIDENTS, OR UNFAVORABLE OR ADVERSE RESULTS WHICH ARE OR SHOULD BE KNOWN TO ME AND WHICH CAN REASONABLY BE EXPECTED TO RESULT IN A CLAIM WILL NOT BE COVERED, WHETHER LISTED ON THIS FORM OR NOT.

DATE: _____ SIGNATURE: _____