MARKEL SHAND, INC.
A Markel Company
Ten Park Way North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager

○ DEERFIELD I
○ EVANSTON I
○ ESSEX INSUR
○ MARKEL AM
○ MARKEL INS

If you obtained this application at www.markelshand.com, please submit this application through your local insurance professional.

APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS
PROFESSIONAL LIABILITY INSURANCE FOR MEDICAL STUDENTS

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD", UNLESS THE OPTIONAL EXTENSION PERIOD IS EXERCISED. THE LIMITS OF LIABILITY SHALL BE REDUCED BY "CLAIM EXPENSES" AND "CLAIM EXPENSES" SHALL BE APPLIED AGAINST THE DEDUCTIBLE.

If space is insufficient to answer any question fully, attach a separate sheet.

1. (a) Full name of Applicant: _____

   (b) U.S. address: _____

   (Street)   (County)

   _____

   (City)   (State)   (Zip)

   (c) Foreign address (if None, so state): _____

   (Street)

   _____

   (City)   (Zip)   (Country)

   (d) Date of birth (MM/DD/YYYY): _____ Place of birth: _____

   (e) Are you a U.S. citizen?...[ ] Yes [ ] No
   If No, provide the following:

   (i) Your status in the U.S.: _____

   (ii) Date of entry into the U.S.: _____

   (iii) Visa/Passport Number: _____

2. (a) Provide the following information for any medical school(s) that you have attended or are currently attending:

Name of Medical School	Address	Dates Attended

   (b) Provide the month and year of graduation or anticipated month and year of graduation:_____

3. (a) Provide the name and address of the facility at which you will receive additional medical training: _____

   (b) Provide the duration of your additional medical program (MM/DD/YYYY): From: _____ To:_____

   (c) Provide the name and title of the person(s) who will be supervising your additional medical program:

   _____

   (d) Will you provide direct patient care: ....[ ] Yes [ ] No
   If No, are your activities limited to observation only?....................................[ ] Yes [ ] No

4. Has (have) any judgment(s), settlement(s), payment(s), claim(s), suit(s) or demand(s) been made against you, such as would fall under the proposed insurance?...[ ] Yes [ ] No
   If Yes, provide details._____

5. Are you aware of any fact, circumstance or situation which might afford grounds for any claim, such as would fall under the proposed insurance?...[ ] Yes [ ] No
   If Yes, provide details._____

6. Has any insurer declined, cancelled or nonrenewed any Medical Professional Liability Insurance Policy or any similar insurance on your behalf? ....[ ] Yes [ ] No
   If Yes, provide details._____

7. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..[ ] Yes [ ] No
   If Yes,
   (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?   [ ] Yes [ ] No
   (b) Provide the name and title of the Applicant's Privacy Officer._____

   Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

AS PART OF THIS APPLICATION ATTACH THE FOLLOWING:

- Resume

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

NO FACT, CIRCUMSTANCE OR SITUATION INDICATING THE PROBABILITY OF A CLAIM OR ACTION FOR WHICH COVERAGE MAY BE AFFORDED BY THE PROPOSED INSURANCE IS NOW KNOWN BY THE APPLICANT PROPOSED FOR THIS INSURANCE OTHER THAN THAT WHICH IS DISCLOSED IN THIS APPLICATION. IT IS AGREED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM SUBSEQUENTLY EMANATING THEREFROM SHALL BE EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS IN THIS APPLICATION AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE. MARKEL SHAND, INC. OR THE COMAPNY IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE COMPANY TO PROVIDE OR THE APPLICANT TO PURCHASE THE INSURANCE.

THIS APPLICATION, INFORMATION SUBMITTED WITH THIS APPLICATION AND ALL PREVIOUS APPLICATIONS AND MATERIAL CHANGES THERETO OF WHICH MARKEL SHAND, INC. RECEIVES NOTICE IS ON FILE WITH MARKEL SHAND, INC. AND IS CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY IF ISSUED. MARKEL SHAND, INC. AND THE COMPNAY WILL HAVE RELIED UPON THIS APPLICATION AND ALL SUCH ATTACHMENTS IN ISSUING THE POLICY.

IF THE INFORMATION IN THIS APPLICATION AND ANY ATTACHMENT MATERIALLY CHANGES BETWEEN THE DATE THIS APPLICATION IS SIGNED AND THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL PROMPTLY NOTIFY MARKEL SHAND, INC., WHO MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION OR AGREEMENT TO BIND COVERAGE.

THE UNDERSIGNED DECLARES THAT HE/SHE UNDERSTANDS THAT:

(I) THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," UNLESS THE OPTIONAL EXTENSION PERIOD IS EXERCISED. IF THE OPTIONAL EXTENSION PERIOD IS EXERCISED, THE POLICY SHALL ALSO APPLY TO "CLAIMS" FIRST MADE DURING THE OPTIONAL EXTENSION PERIOD;

(II) THE LIMITS OF LIABILITY CONTAINED IN THE POLICY SHALL BE REDUCED, AND MAY BE COMPLETELY EXHAUSTED BY "CLAIM EXPENSES" AND, IN SUCH EVENT, THE COMPANY WILL NOT BE LIABLE FOR "CLAIM EXPENSES" OR THE AMOUNT OF ANY JUDGEMENT OR SETTLEMENT TO THE EXTENT THAT SUCH COSTS EXCEED THE LIMITS OF LIABILITY IN THE POLICY; AND

(III) "CLAIM EXPENSES" SHALL BE APPLIED AGAINST THE DEDUCTIBLE.

Must be signed by the Applicant (within 60 days of the proposed effective date).

_____   _____

Signature of Applicant   Date

FRAUD PREVENTION – WARNING
ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY MISLEADING INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION, AND CONFINEMENT IN STATE PRISON.

BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

        Address
        City, State, Zip
        States of Licensure
        New or Renewal for Markel Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

        Name of Carrier:_____

        Limits:_____   Deductible:_____   Premium:_____

        Expiration Date: _____   Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: