HUDSON INSURANCE GROUP

HUDSON SPECIALTY INSURANCE COMPANY

Small Group and Individual Physician Application

for surplus lines coverage

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.
-If a question does not apply to you, write "N/A". Please do not leave any questions unanswered.
-Include a copy of the following: 1. CV 2. Letterhead 3. State & DEA License
4. Current Declarations Page 5. Currently valued insurance company generated Loss Runs.

BROKER _____

PERSONAL DATA

Last Name _____ **First Name** _____ **M.I.** _____ **Title** _____

Date of birth: _____ Social Security No.: _____

Clinic name/Employer: _____

Office address: _____ Office telephone: ( )_____

City/State/Zip: _____ County _____

Number of years at current office location: _____ % of practice at this location: _____

List all other office locations where you will practice your profession:

Address: _____ City/State/County: _____

Address: _____ City/State/County: _____

Residence address: _____ City/State/County: _____

Residence telephone: ( )_____

INSURANCE COVERAGE REQUEST

Requested effective date: _____ Prior Acts Date (Retroactive Date)_____

Requested limits of liability (per claim/aggregate):

❒ $1,000,000/$3,000,000 ❒ Other: $_____

Deductible (per claim/aggregate):

❒ None ❒ $10,000 /$30,000 ❒ $25,000 /$75,000 ❒ Other:$_____

MEDICAL SPECIALTY

Current Medical Specialty: _____ % of practice _____

❒ Surgery ❒ Minor Surgery ❒ No Surgery

Sub Specialty: _____ % of practice _____

❒ Surgery ❒ Minor Surgery ❒ No Surgery

MEDICAL TRAINING AND HISTORY

1. Medical school name: _____

   City: _____ State: _____ Country _____ Year graduated: _____

2. If you are a graduate of a foreign medical school:

   Are you certified by the Education Council for Foreign Medical Graduates? ❒ Yes ❒ No

   Have you passed the United States Medical License Exam (USMLE)? ❒ Yes ❒ No

3. Residency (1) (Name of institution): _____ City/State: _____

From: _____ To: _____

Specialty: _____ Residency completed? ❒ Yes ❒No

If "No", explain: _____

Residency (2) (Name of institution): _____City/State: _____

From: _____ To: _____

Specialty: _____ Residency completed? ❒Yes ❒ No

If "No", explain: _____

4. Fellowship (Name of institution): _____ City/State: _____

From: _____ To: _____ Specialty: _____ Fellowship completed? ❒Yes ❒ No

If "No", explain: _____

5. Medical License #: _____ State: _____ Expiration date: _____ Status: _____

Medical License #: _____ State: _____ Expiration date: _____ Status: _____

Medical License #: _____ State: _____ Expiration date: _____ Status: _____

6. Narcotics/DEA license #: _____ Expiration date: _____ Status: _____

BOARD CERTIFICATION

1. Are you Board Certified? ❒Yes ❒No

Board name: _____

Date Certified_____ Expiration Date _____

Board name: _____

Date certified: _____ Expiration Date _____

2. If you are not Board certified, are you eligible to take the boards in your specialty? ❒Yes ❒No

Do you plan to take the Board exam (both written and oral exams)? ❒ Yes ❒ No

When do you plan to take the Board exam? _____

3. Have you ever been denied Board certification or recertification or have you allowed your certification to lapse ? If "Yes", state reason: _____ ❒Yes ❒ No

PRACTICE INFORMATION

1. Do you have hospital privileges? ❒Yes ❒ No

Type of privileges

Hospital name: _____ ❒Full ❒Restricted

City/State/County: _____ ❒Courtesy ❒Other

Hospital name: _____ ❒ Full ❒Restricted

City/State/County: _____ ❒ Courtesy ❒Other

Hospital name: _____ ❒Full ❒Restricted

City/State/County: _____ ❒Courtesy ❒Other

2. Average/estimated # of hours worked per week: _____ Average/estimated # of patient visits per week: _____

(If you have answered "No", "Restricted" or "Other" to question #1, explain on your letterhead.)

3. Type of Practice (check all that apply):

- ❒ Individual / Solo corporation – Name of corporation: _____
- ❒ Partnership – Name of partnership: _____
- ❒ Employed doctor – Name of employer: _____
- ❒ Independent contractor – Name of physician, partnership or corporation with whom you contract: _____

4. Indicate extent of professional relationship between the physician members (check all that apply):

- ❒ Common letterhead
- ❒ See each other's patients on a regular basis
- ❒ Share overhead expenses
- ❒ Common billing statements (as opposed to utilizing the same billing service)
- ❒ Share professional employees (e.g., R.N., Technician)
- ❒ All physicians' names appear together on the office door
- ❒ Other (describe) _____

5. Do you request coverage for your corporation? ❒ Yes ❒No

6. Do you, your partnership or corporation, employ any of the following non-physician providers? If yes, please complete the information below. Indicate the number of each type of professional employed or contracted by the physician. Use a separate sheet, if necessary:

Number of Professional Employees			**Number of Other Healthcare Employees**		
	Employees	**Independent Contractors**		**Employees**	**Independent Contractors**
*Physician/Dentist			Marriage, Family & Child Counselor		
*Resident			Nurse		
*Nurse Anesthetist			Optometrist		
*Nurse Midwife			Perfusionist		
*Nurse Practitioner			Physical Therapist		
*Physician Assistant			Athletic Trainer		
*Podiatrist			Chiropractor		
*Psychologist			Licensed Clinical Social Worker		
Other			Other		

(* Complete a Small Group and Individual Physician Application for each Professional Employee)

7. Have there been any changes in your specialty, classification or practice activity within the last 5 years? ❒ Yes ❒No
   If "Yes", explain: _____
8. Does your current practice involve the treatment of nursing home residents? ❒ Yes ❒No
   If "Yes", what percentage of your practice involves treatment of nursing home residents? _____ %
9. Does your current practice involve the treatment of prison inmates? ❒ Yes ❒No
   If "Yes", what percentage of your practice involves treatment of prison inmates? _____ %
10. Do you have a faculty appointment? ❒ Yes ❒ No If "Yes", provide name of insurance carrier for the educational program _____.
11. Does your current practice involve working in an Emergency Department? ❒Yes ❒No
    If "Yes", how many hours each week do you work in an Emergency Department? _____ hours/week
12. Do you perform or assist in any surgical procedure in a <u>non-hospital setting</u>, other than an Ambulatory Surgery Center, during which any anesthesia is administered? ❒Yes ❒No If yes, please explain_____
13. Are you employed or contracted to any facility as the medical director? ❒Yes ❒No If "Yes", provide name of insurance Carrier _____.
14 . Do you have any medical related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ❒Yes ❒No If yes, please explain _____

MEDICAL PROCEDURES

Check all procedures that you perform. If you do not perform any of the procedures listed below, check here ❒

Office	Hospital	Other	Procedure
			Abortion (Do you perform elective abortions?) ❒ Yes ❒No If yes, which trimester _____ # per year _____
			Acupuncture
			Amniocentesis
			Angiography / Arteriography ❒ cardiac ❒ peripheral
			Angioplasty ❒ cardiac ❒ peripheral
			Appendectomy
			Arterial/Venous Line Placement
			Arthroscopic procedures *
			Bariatric Surgery * (annual # performed _____) specific type_____
			Blepharoplasty
			Botox injections ❒ cosmetic / ❒ medically indicated
			Breast Surgery (Do you perform implants?) ❒Yes ❒ No # per year _____
			Bronchoscopy
			Cardiac Catheterization
			Chelation Therapy ❒Lead Removal ❒ Arteriosclerotic Heart Disease
			Colonoscopy ❒with anesthesia ❒ without anesthesia
			Cosmetic Plastic Surgery * ❒ **Reconstructive Plastic Surgery** ❒
			Dermabrasion * (indicate % of time devoted to this procedure) _____ %
			Dilatation & Curettage (D&Cs)
			Electroconvulsive Therapy
			ERCP (Endoscopic Retrograde Cholangiopancreatography)
			EVLT * (Endovenous Laser Treatment) ❒ Schlerotherapy * ❒ Vein Stripping
			GI Endoscopy ❒ with anesthesia ❒without anesthesia
			Hair Transplants * / Scalp excision/ Transplantations ❒ Yes ❒ No Plug technique/Mini graphs ❒ Yes ❒ No
			Hemodialysis
			Kyphoplasty ❒ **Vertebroplasty *** ❒
			Laparoscopic procedure(s) ❒ diagnostic ❒ therapeutic
			Liposuction * (indicate % of time devoted to this procedure) _____ %
			Lithotripsy
			Lumbar Puncture ❒ **Myelography** ❒
			Lymphangiography
			Needle Biopsy (including lung, prostate, liver & kidney)
			Obstetrical deliveries (enter # per year for each) C-Sections _____ Vaginal _____VBAC _____
			Occipital Nerve Blocks
			Pacemaker Insertions (annual # performed permanent / temporary ____/____)
			Phenol Facial Peels *
			Professional Sports Medicine
			Sex Change Operations
			Spinal Surgery
			Swan-Ganz Catheterization (annual # performed _____)
			Tubal Ligations
			Vision Correction Surgery - type(s) performed:_____
			Weight Reduction (annual # performed _____) Do you prescribe any medication? ❒ Yes ❒No If yes, please explain_____

*** Attach summary of training for this (these) procedure(s).**

SURGERY RATING INFORMATION (these definitions are not all inclusive)

❒ **No Surgery** -Includes normal office procedures as commonly found in a family practice. Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered "No Surgery". This includes administration of local or topical anesthesia and circumcision. No invasive procedures or special procedures room activities are done.

❒ **Minor Surgery** – Includes all listed in definition of "No Surgery", as well as assisting in major surgery, D&C, and vasectomies. Invasive procedures are done, but the procedures do not open or enter a major body cavity.

❒ **Major Surgery** – Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, any other operation, which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life, removal of tumors, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation done using general anesthesia, and the administration of anesthesia other than local or topical.

INSURANCE HISTORY

1. Current carrier name: _____ ❒ Claims Made ❒ Occurrence

   Effective date: _____ Expiration date: _____ Prior Acts Date: _____

   Limits of liability: _____ Per claim _____Aggregate

   ❒ Deductible ❒ SIR $: _____ Per claim _____Aggregate

   Annual premium: _____

   First prior carrier name: _____ ❒ Claims Made ❒ Occurrence

   Effective date: _____ Expiration date: _____ Prior Acts Date: _____

   Limits of liability: _____ Per claim _____Aggregate

   ❒Deductible ❒SIR $: _____ Per claim _____Aggregate

   Second prior carrier name: _____ ❒ Claims Made ❒ Occurrence

   Effective date: _____ Expiration date: _____ Prior Acts Date: _____

   Limits of liability: _____ Per claim _____Aggregate

   ❒Deductible ❒ SIR $: _____ Per claim _____Aggregate

2. If you are currently insured on a claims made policy, are you obtaining Extended Reporting Period (tail) Coverage from your current insurance carrier? ❒ Yes ❒ No

   Note: To prevent possible gaps in your Claims Made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. ***Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.***

3. Where have you practiced your profession since completion of your formal training? (include military or any public service organization) **Account for all time since medical school**. **Explain any gaps in your education or professional practice history.** ***If your attached CV provides the same information, go on to the next question.***

   City/State: _____ From: _____ To: _____

   ❒ Solo practitioner ❒ Part of a group Group name: _____

   City/State: _____ From: _____ To: _____

   ❒Solo practitioner ❒Part of a group Group name: _____

   City/State: _____ From: _____ To: _____

   ❒ Solo practitioner ❒Part of a group Group name: _____

UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.
Within the past 10 years:

1. Are you being investigated or have you been convicted of a misdemeanor (other than traffic related) or felony or is any such charge pending?	❒ Yes ❒ No
2. Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program?	❒ Yes ❒ No
3. Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis?	❒ Yes ❒ No
4. Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility?	❒ Yes ❒ No
5. Have you ever resigned from a health care facility while under investigation or to avoid possible disciplinary action?	❒Yes ❒No
6. Has any hospital as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision?	❒Yes ❒No
7. Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?	❒ Yes ❒ No
8. Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	❒ Yes ❒ No
9. Have Medicare or Medicaid authorities ever investigated or brought charges against you?	❒ Yes ❒ No
10. Have you provided any professional services without professional liability insurance?	❒ Yes ❒ No
11. Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	❒ Yes ❒ No
12. Have you ever treated any patients by means of unconventional therapeutics, or utilized FDA experimental drugs other than through Institutional Review Board (IRB) approved research programs?	❒ Yes ❒ No
13. Does your practice include telemedicine or teleradiology?	❒ Yes ❒ No

CLAIMS INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.
Within the past 10 years:

1. Have you been involved in a malpractice claim, lawsuit, incident or occurrence in the last 10 years? If "Yes", how many?_____	❒ Yes ❒ No
2. Are you aware of any circumstances that may result in a malpractice claim or suit being made or being brought against you?	❒ Yes ❒ No
3. Are you aware of any outstanding incidents, claims, or suits (even if you believe the outstanding claim or suit would be without merit) that have <u>not</u> been reported to your current or prior professional liability carrier?	❒Yes ❒No
4. Have you been contacted by a plaintiff's attorney or required to produce medical records or statements regarding any case you have been involved with, regardless of whether you have been specifically named in the suit or claim?	❒ Yes ❒ No

COMMENTS

_____

_____

_____

_____

_____

_____

_____

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application shall be the basis of the contract should a policy be issued. I agree to notify the Company of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to the following:

A. A change in specialty or medical procedures performed;
B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
C. Investigation, restriction, suspension or surrender of any state medical, DEA license or hospital privileges;
D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing.
E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

For FL, KY, MN, NJ, OH and PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person who files an Application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. For NY residents only: And shall also be subject to a civil penalty not to exceed five thousand ($5,000) dollars and the stated value of the claim for each such violation.

This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company. Your risk is not protected by the state insurance insolvency fund, and the insurer from which your purchasing group obtained its insurance may not be subject to all of the insurance laws and rules of this state.

_____ _____
Signature in full **Date**

_____
Print name

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

Hudson Specialty Insurance Company has issued a policy to the Hudson Healthcare Purchasing Group, a risk purchasing group located and domiciled in Washington DC, registered in Ohio and established pursuant to legislation enacted by Congress known as the Federal Liability Risk Retention Act of 1986. Your application is for insurance coverage derived from, and admission as a member to, the Hudson Healthcare Purchasing Group. If your application is accepted, you will become a member of the Hudson Healthcare Purchasing Group and you will be entitled to insurance coverage from Hudson Specialty Insurance Company.

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

HUDSON SPECIALTY INSURANCE COMPANY
Supplement Claim Information Form

(make copies of this page as needed)

1. Name of patient: _____ Age: _____ ❒ Male ❒ Female

2. Describe the allegation made by claimant: _____

_____

_____

_____

3. Date claim was made or filed: _____

4. Date of alleged incident: _____

5. Insurance company: _____

6. Additional defendants: _____

7. Disposition of claim: ❒Open ❒ Closed

If open:
- Claimant's settlement demand: $ _____
- Defendant's offer for settlement: $ _____
- Insurer's loss reserve: $ _____
- Deductible amount: $ _____
- Is claim in suit? ❒ Yes ❒ No — If "Yes", amount asked in summons: $_____

If closed:

Date closed: _____

❒ Court judgment ❒Out of court settlement ❒ Dismissed with prejudice ❒ Dismissed without prejudice

- Total indemnity paid (including deductible): $ _____
- Total defense costs/ expenses paid $ _____
- **Total costs incurred** **$ _____**

Provide complete and detailed information for evaluation. Use reverse side or additional sheets if required.

8. Condition and diagnosis at time of incident (include dates of visits)

_____

_____

9. Description of treatment rendered (include dates of visits)

_____

_____

10. Condition of patient subsequent to treatment (include dates of follow-up treatment)

_____

_____

_____ _____

Signature of applicant Date

HUDSON SPECIALTY INSURANCE COMPANY

A. GENERAL FRAUD STATEMENT
(Not applicable in Colorado, Ohio, Oklahoma and Utah)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false 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 the person to criminal and (NY: substantial) civil penalties.

_____ _____

Applicant's Signature **Date**

_____

Print Name

B. FRAUD STATEMENT(S)

UTAH FRAUD STATEMENT
(Workers' Compensation)

For your protection, Utah law requires the following to be included in this application:

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

OKLAHOMA FRAUD STATEMENT
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OHIO FRAUD STATEMENT
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

COLORADO APPLICATION SUPPLEMENT
This Notice is a part of your application for:

- ❒ HOMEOWNERS INSURANCE
- ❒ PERSONAL LINES PACKAGE INSURANCE
- ❒ PERSONAL INLAND MARINE INSURANCE
- ❒ PERSONAL AUTO INSURANCE
- ❒ WATERCRAFT INSURANCE
- ❒ COMMERCIAL INSURANCE
- ❒ PERSONAL UMBRELLA INSURANCE
- ❒ DWELLING INSURANCE
- ❒ AGRICULTURE INSURANCE
- ❒ MOBILE HOME INSURANCE

FRAUD WARNING

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

_____ _____

Applicant's Signature **Date**

_____

Print Name