PROFESSIONAL UNDERWRITERS LIABILITY INSURANCE COMPANY
A TDC Company

PHYSICIAN'S PROFESSIONAL LIABILITY POLICY NEW BUSINESS APPLICATION

Instructions: All questions must be answered. Please type or print clearly. No coverage is in place until application is approved and premium paid. All requested explanations and documents must be attached including: current declarations page, CV & currently valued loss runs.

NOTICE
This is an application for a CLAIMS-MADE POLICY

1. (a) Applicant's Full Name:_____ Degree/Title:_____

   Other Name Used:_____ Birth Date:_____

   (b) Social Security #:_____ (c) Federal DEA #:_____ Male ☐ Female ☐

   (d) Home Address:_____ Phone: (_____)_____
   Number Street City County State Zip

   (e) Principal Office:_____ Phone: (_____)_____
   Number Street City County State Zip
   Fax: (_____)_____

   (f) Other Office Address(es): (if any)_____ Phone: (_____)_____
   Number Street City County State Zip
   Email: _____

2. Specify States where you are licensed:

   _____ _____ _____
   (License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field)

3. (a) Medical Specialty:_____ (b) Sub-Specialty:_____ % of Practice:_____

   If your specialty is Pain Management, Neurosurgery or Bariatric Surgery you will need to complete an additional procedure questionnaire.

4. (a) What is your average weekly patient load?_____ (b) How many surgical procedures do you perform each week?_____

5. If my application is approved, make coverage effective on _____, if possible, otherwise on any other date set by the Company.

6. (a) Type of Practice (check all boxes that apply):

   1. ☐ Individual (solo) Unincorporated
   2. ☐ Individual (solo) Corporation
   3. ☐ Partnership
   4. ☐ Member of Multi-person Corporation or Association
   5. ☐ Employee of:_____
   6. ☐ Independent Contractor of:_____
   7. ☐ Other (Describe) _____

   (b) List Federal Taxpayer Identification Number(s) and name(s) of corporate entity(ies):

   _____
   Entity Name Federal Taxpayer Identification Number

   _____
   Entity Name Federal Taxpayer Identification Number

   (c) Please list name(s) of ALL other partners, stockholders, associates, independent contractors and employed physicians. **(Indicate status of each and provide proof of coverage for each).**

   1. _____ 3. _____
   Name Current Limits Name Current Limits

   2. _____ 4. _____
   Name Current Limits Name Current Limits

7. (a) Are you American Board Certified in your Specialty? ☐ YES ☐ NO Date(s) Certified:_____

   (b) Are you American Board Certified in your Sub-Specialty? ☐ YES ☐ NO Date(s) Certified:_____

   (c) Name(s) of Specialty Board(s): _____

   _____

   (d) If you are a foreign medical graduate, are you certified by the Educational Commission for Foreign Medical Graduates? ☐ YES ☐ NO

   (e) Have you ever failed any Board Certification testing? ☐ YES ☐ NO

   If YES, please explain:_____

ATTESTATION QUESTIONS

8. **If the answer to any of the following is YES, please give full details (including dates) on a separate sheet of paper:**	YES	NO
(a) Have you ever had professional liability insurance declined, canceled, issued on special terms or non-renewed?	☐	☐
(b) Have you ever been investigated or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? **(If YES, provide copies of all Accusations, Decisions, Consent Orders, etc.)**	☐	☐
(c) Has or is your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?	☐	☐
(d) Have you ever had privileges at any hospital or other institution denied, reduced, revoked, restricted, or suspended?	☐	☐
(e) Are you currently or have you ever been evaluated, treated or hospitalized for alcohol or drug abuse or a mental or emotional disorder?	☐	☐
(f) Have you ever been convicted of, or are you under indictment for, a felony?	☐	☐
(g) Has your membership in any professional society or association ever been refused, censured, suspended or revoked?	☐	☐
(h) Do you currently have or have you ever had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine?	☐	☐
(i) Are you currently or have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties?	☐	☐
(j) Has any physician, patient or insurance plan ever filed a complaint against you with any Medical Association/ Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau?	☐	☐
(k) Have you ever been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)?	☐	☐
(l) Have you ever been involved in a malpractice claim, suit or medical incident, either directly or indirectly, or are you presently involved in malpractice litigation? **(If YES, please complete a Claims Information Form for each.)**	☐	☐
(m) Are you aware of any facts, circumstances, medical incidents, records requests or letters of intent that may give rise to a claim or suit? **(If YES, please complete a Claims Information Form for each, attached to this Application).**	☐	☐

TRAINING & INSURANCE HISTORY

9. (a) Medical Degree from (school):_____ Dates:_____
City State Country mm/dd/yy to mm/dd/yy

(b) Internship:_____ Dates:_____
Hospital City State Country mm/dd/yy to mm/dd/yy

(c) Residency:_____ Dates:_____
Hospital City State Country mm/dd/yy to mm/dd/yy

(d) Type of Residency:_____

(e) Residency:_____ Dates:_____
Hospital City State Country mm/dd/yy to mm/dd/yy

(f) Type of Residency:_____

(g) Fellowship Training:_____ Dates:_____
Hospital City State Country mm/dd/yy to mm/dd/yy

(h) Type of Fellowship:_____

10. List any additional medical specialty training:

Location	Type	Dates

11. List malpractice coverage for the past **10** years, beginning with your current or most recent carrier:

Name of Insurer	Dates Covered From – To (MM/DD/YY)	Limits of Liability	Retro-active Date	Coverage Type (Occurrence or Claims-Made)	Premium	Was Tail Coverage Purchased?	# of Pending Claims	# of Closed Claims	Total # of Claims
A									
B									
C									
D									

1. **PLEASE ATTACH A COPY OF YOUR MOST RECENT DECLARATION'S PAGE AND POLICY.**
2. **PLEASE FILL OUT A CLAIM INFORMATION FORM FOR EACH SUIT, CLAIM, LETTER OF INTENT AND INCIDENT, OPEN OR CLOSED, AND SUBMIT ANY ADDITIONAL INFORMATION RELATIVE TO THESE CLAIMS.**

(a) Do you intend to purchase a reporting endorsement (a.k.a. Tail Coverage) from your current insurer? YES ☐ NO ☐

(b) If answer to (a) is NO, do you wish to obtain Prior Acts Coverage from us? **NOTE: The offering of Prior Acts Coverage is subject to Underwriter approval.** YES ☐ NO ☐

(c) If answer to (b) is YES, please attach a copy of your present insurance policy, with all endorsements, and complete the following:

Applicant is/is not **(circle one)** as of this date aware of any Claims, Suits, Letters of Intent, Records Requests or Incidents that have not been reported to his/her **(circle one)** present or prior insurer(s). Please Initial:_____

NOTE: If you do not purchase Prior Acts Coverage from us you will not have any coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.

PRACTICE QUESTIONS

12. (a) Do you perform surgery in your office? YES ☐ NO ☐

(b) Do you perform surgery in any other non-hospital facility? YES ☐ NO ☐

If answer to (b) is YES, list and describe facilities where surgery is performed:_____

_____

(c) Is general anesthesia administered:

1. By you? YES ☐ NO ☐
2. By others? YES ☐ NO ☐

(d) List the surgical procedures you perform in your office or other non-hospital facility:

_____

_____

13. (a) Do you treat or review the treatment of prison inmates? YES ☐ NO ☐ % of practice:_____

If YES, please explain (include facility names):_____

(b) Is insurance coverage provided for this work by the above facility? YES ☐ NO ☐

14. (a) Do you practice as a professional sports team physician? YES ☐ NO ☐ % of practice:_____

(b) Do you practice as an amateur sports team physician? YES ☐ NO ☐ % of practice:_____

If YES, please explain (include duties, team names and type of sport):_____

15. Do you perform medical legal evaluations? YES ☐ NO ☐ % of practice:_____

If YES, with whom?_____

16. Do you treat or consult on patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands?

YES ☐ NO ☐ If YES, where?_____ % of practice:_____

17. Do you advertise your medical practice? YES ☐ NO ☐ If YES, what states:_____

If YES, list medium(s) and frequency for each:_____

If YES, provide copies of advertisements that you are currently using or have placed in periodicals, yellow pages, on flyers, handouts, etc. Please provide a copy of the script if you are using voice or film media.

18. Do you have any Internet Web-Site addresses? YES ☐ NO ☐ If YES, specify addresses:_____

_____

19. Do you perform consultations outside the state of your primary office address, including but not limited to, the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (tele-medicine or internet medicine) or do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address?

YES ☐ NO ☐ If YES, what percentage of your total practice:_____

If YES, identify all states in which such patients reside:_____

20. Do you treat patients who reside outside the state of your primary office address? YES ☐ NO ☐

If YES, what percentage of your practice:_____

21. List all locations where you have practiced in the last 10 years:

	Group Name	Street	City	County	State	During Years
(a)						
(b)						
(c)						
(d)						

22. Do you (YES☐ NO☐) or your professional entity (YES☐ NO☐) employ or contract for the services of any health care personnel? If YES, provide number of each and indicate if coverage (shared limits) is desired for each. **NOTE: If employed by an entity, coverage may not be available.**

		# Employed	Is Coverage Desired?	# of Independent Contractors	Are they Insured?
(a)	Nurses (RN, LPN, LVN)		YES ☐ NO ☐		YES ☐ NO ☐
(b)	Medical Assistants		YES ☐ NO ☐		YES ☐ NO ☐
(c)	Technicians		YES ☐ NO ☐		YES ☐ NO ☐
(d)	Psychologists		YES ☐ NO ☐		YES ☐ NO ☐
(e)	Physical Therapists		YES ☐ NO ☐		YES ☐ NO ☐
(f)	Physician's Assistants**		YES ☐ NO ☐		YES ☐ NO ☐
(g)	Nurse Practitioners**		YES ☐ NO ☐		YES ☐ NO ☐
(h)	CRNA's**		YES ☐ NO ☐		YES ☐ NO ☐
(i)	Nurse Midwives**		YES ☐ NO ☐		YES ☐ NO ☐
(j)	Other:_____		YES ☐ NO ☐		YES ☐ NO ☐
(k)	Other:_____		YES ☐ NO ☐		YES ☐ NO ☐

****If YES, please submit a written explanation of practice and procedures performed, along with certificate of course completion and license number. Provide proof of insurance if insured elsewhere. If coverage is desired, please complete a Professional Underwriters Liability Insurance Company Allied Personnel Application for each.**

23. Are you associated in any capacity with, or do you own, any of the following:

(a) Any health care facility having bed and board accommodations? YES ☐ NO ☐

(b) Any surgicenter, clinic, urgent care center, foundation, blood bank, laboratory, abortion clinic or birthing center? YES ☐ NO ☐

If answer to (a) or (b) is YES, are you:

1. ☐ Owner (whole or part) 3. ☐ Executive Officer 5. ☐ Director of Ancillary Services Dept. 7. ☐ Administrator
2. ☐ Committee Member 4. ☐ Medical Director 6. ☐ Other (explain)_____

(c) Any other medically related business enterprise? YES ☐ NO ☐

If answer to (c) is YES, please explain:_____

24. Are you a physician with teaching responsibilities? YES ☐ NO ☐

If YES, please explain:_____

If YES, is insurance coverage provided by this institution or facility? YES ☐ NO ☐

25. List all facilities (i.e. hospitals, surgicenters, etc) where you are currently on staff and show percentage of work in each facility:

	Facility Name	City	County	State	Type of Privileges	Percentage of Work
(a)						
(b)						
(c)						
(d)						

26. (a) Are you a "Hospitalist"? YES ☐ NO ☐

(b) Do you work in any Emergency Room? YES ☐ NO ☐

If YES to (b), is it required solely to maintain staff privileges? YES ☐ NO ☐

(c) Do you provide any Locum Tenens services? YES ☐ NO ☐

(d) Do you "moonlight" at any other facilities? YES ☐ NO ☐

(e) Do you provide any services at a hotel, spa or health club? YES ☐ NO ☐

(f) Do you provide pre or post operative care or follow-up for any bariatric surgery patients? YES ☐ NO ☐ % of Practice:_____

If YES to any of the above, please explain:_____

27. Do you treat patients in any nursing home, skilled nursing facility or assisted living center? YES ☐ NO ☐

If YES, % of practice:_____ If YES, do you treat other than your own patients? YES ☐ NO ☐

28. Are you a medical director of any nursing home, skilled nursing facility or assisted living center? YES ☐ NO ☐

If YES, provide evidence of coverage for each facility.

29. Do you use experimental devices or drugs or do you perform experimental procedures or therapy in treatment or surgery or are you a principal investigator for any clinical trial?

YES ☐ NO ☐

If YES, do you follow FDA approved protocols? YES ☐ NO ☐ If YES, describe:_____

30. Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? YES ☐ NO ☐

If YES, have you implemented procedures to comply with the HIPAA Privacy Rule? YES ☐ NO ☐

31. How many days do you work per week?_____ Hours per day?_____

32. What % of your patient's are: (a) over age 65?_____ (b) Age 18 or younger?_____ (c) Hospitalized Patient's?_____

33. Has your practice (e.g. specialty, procedures or practice environment) changed in the last five years? YES ☐ NO ☐

If YES, please explain:_____

EXPLANATIONS, REMARKS & NOTES:_____

PROCEDURAL QUESTIONS

For each procedure in Section (a) through (j) below, please provide the approximate number of times you have "Performed" or "Assisted" during the past 12 months as well as how many times you anticipate doing so during the next 12 months. If you Perform or Assist in other procedures not listed below, add each one under "Other" in each section.

34. (a) General Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Alternative/Holistic Medicine (explain) _____				
Angiography				
Angioplasty				
Anti-Aging Medicine (explain) _____				
Arterial Catheterization				
Arteriography (explain type) _____				
Bronchoscopy				
CCU Care (other than admitting)				
Chelation Therapy (explain) _____				
Chemotherapy				
Colonoscopy				
Cardiac Catheterization				
Cardiac Cath. - Right Heart Only				
Cryosurgery (explain) _____				
Dialysis Procedures				
Elective Cardioversion				
Endoscopy (explain) _____				
Hair Transplants				
Hypnosis				
IVP				
Laser Therapy (explain) _____				
Lymphangiography				
Myelography				
Paracentesis or Thoracentesis				
Polypectomy by Endoscopy				
Venography				
Weight reduction or weight control				

If YES, % of practice:_____

List methods, drugs prescribed:_____

☐ **NONE OF THE ABOVE**

34. (c) Pediatric Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Circumcisions				
Neonatology				
If YES, % of practice:_____				
Umbilical Catheterization & Monitoring				
Other (specify below)				

_____

_____

☐ **NONE OF THE ABOVE**

34. (b) Gynecology Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Abortions - your patients				
1st trimester – your patients				
after 12 weeks – your patients				
Abortions – other patients				
1st trimester – other patients				
after 12 weeks – other patients				

List names of facilities where you perform abortions:

_____

A & P repair				
Cervical Cautery				
Cold Conization Cervix				
Culdocentesis				
Dilation & Curettage				
Ectopic Pregnancy				
Hysterectomy - Vaginal				
Hysterectomy - Abdominal				
Insertion of IUD				
In vitro fertilization				
If YES, % of practice_____				
Laparoscopy				
Office Gynecology				
Oophorectomy or Salpingectomy				
Tubal Ligation				
Other (specify below)				

_____

Do you own or operate a sperm bank for:
the treatment of your patients? YES ☐ NO ☐
the treatment of others' patients? YES ☐ NO ☐

☐ **NONE OF THE ABOVE**

34. (d) Obstetrical Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Amniocentesis – 3rd trimester only				
Amniocentesis – 1st or 2nd trimester				
Breech Delivery				
Cesarean Sections				
Episiotomy				
Low forceps				
Managing Toxemia				
Mid forceps				
Normal deliveries				
Prenatal care				
Home deliveries				
Other non-hospital deliveries (explain) _____				
VBAC				
Other (specify below)				

_____

_____

_____

☐ **NONE OF THE ABOVE**

34. (e) Surgical Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Adenoidectomy				
Anal Fissure				
Anal Fistulectomies				
Any surgical procedure involving cutting into or within the abdominal cavity, chest cavity, orbital cavity, spine or facial sinuses				
Any surgical procedures on malignant lesions except for diagnostic purposes				
Amputations				
Appendectomies				
Aspiration of Cyst of Breast				
BCIR				
Biopsies				
If YES, explain types:				
Cholecystectomies - Open				
Chymopapian Injections				
Hemorrhoidectomies				
Hernioplasties				
Herniorrhaphy (inguinal or femoral only)				
Laparoscopic Cholecystectomies				
Mastectomy				
Mastoidectomy				
Minor Office Surgery				
Myringotomy				
Nasal Polypectomy				
Operations within the middle or inner ear				
Organ transplants				
If YES, explain:				
Otorhinolaryngology				
Peripheral Nerve Surgery				
Prostatectomy				
Reconstructive vascular surgery, thromboembolectomy and/or thrombectomy of the arteries or veins				
Repair of laceration not involving nerve or tendon				
Submucous nasal resections				
Surgical treatment of cysts, superficial abscesses, minor traumatic wound & superficial biopsies				
Surgical Weight Reduction				
If YES, please complete a Bariatric Surgery Questionnaire				
Thyroidectomy				
Tonsillectomy				
Vein Stripping				
Other (specify below)				

☐ **NONE OF THE ABOVE**

34. (f) Urological Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Any cutting into or on the kidney, ureter or bladder				
Aspiration of Hydrocele				
Circumcisions				
Orchidectomy				
Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)				
Prosthetic implants				
Sex Change Surgery				
Treatment of Torsion of the Testicle				
Vasectomy				
Other (specify below)				

☐ **NONE OF THE ABOVE**

34. (g) Anesthesia Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Acupuncture				
If YES, for anesthesia?				
Caudal				
Digital Block				
General				
Intravenous Anesthesia				
Intravenous Analgesia				
Nitrous Oxide				
Obstetrical Anesthesia				
Pain Blocks				
Pain Management				
If YES, please complete a Pain Management Questionnaire				
Peripheral Nerve Block				
Spinal Anesthesia				
Other (specify below)				

If YES for any Anesthesia type, check locations where performed:

☐ Hospital ☐ Surgicenter ☐ Non-hospital facility

Do you perform Anesthesia for any Genital Cosmetic Surgery procedures? YES ☐ NO ☐

Do you perform Anesthesia for any Bariatric Surgery procedures? YES ☐ NO ☐

Do you employ:

any inhalation therapists? YES ☐ NO ☐

Have you assumed supervisory duties over:

any nurse anesthetists? YES ☐ NO ☐

any inhalation therapists? YES ☐ NO ☐

☐ **NONE OF THE ABOVE**

34. (h) Plastic & Cosmetic Procedures:

	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Autologous Fat Injection				
Blepharoplasty (cosmetic)				
Botox injections				
If YES, location where performed, by whom & what procedure/purpose?				
Breast Reduction				
Breast Enhancement - Silicone				
Breast Enhancement - Saline				
Breast Enhancement - Trans-Umbilical				
Chemical Peels				
Collagen Injections				
Coronal Lift				
Dermabrasion				
Hair transplants or suturing of hair pieces				
Injection treatment of varicose veins				
Laser Therapy (explain)				
Laser Vaginal Rejuvenation (includes cosmetic and/or plastic surgery procedures performed on the vagina and associated structures. This includes, but is not limited to, vaginoplasty, labiaplasty, laser and non laser rejuvenation procedures)				
Liposuction – under 3500 cc's				
Liposuction – 3500 cc's or more				
Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)				
Rhinoplasty				
Silicone implants (types & where)				
Silicone injections				
Other (specify below)				

☐ **NONE OF THE ABOVE**

34. (i) Orthopedic & Neurosurgical Procedures:

	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Any Operative Orthopedics				
Arthroscopy or Arthrography				
Injection of Bursa				
Joint implants				
Neuro implant surgery for pain				
Open Reduction of Fractures				
Prolotherapy				
If YES, do you use Phenol?_____				
Repair of Extensor Tendon				
Repair of Flexor Tendon				
Spinal Surgery				
Anterior Cervical Discectomies				
Cervical Laminectomies				
Lumbar Laminectomies				
Pedicle Screw				
Scoliosis Surgery				
Stereotactic neurosurgery				
Other (specify below)				

☐ **NONE OF THE ABOVE**

34. (j) Ophthalmology Procedures:

	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Automated Lamellar Keratotomy				
Blepharoplasty (cosmetic)				
Blepharoplasty (functional)				
Cataract Surgery				
Chalazion Excision from eyelids				
Corneal Transplants				
Enucleation				
Hexagonal Keratotomy (HK)				
Intraocular Lens Implant				
Iridectomy				
LASIK				
Lid Repair – Ectropion & Entropion				
Photo-refractive Keratotomy (PRK)				
Pterygium Excision				
Refraction's				
If YES, type:_____				
Removal of Eyelid Lesion				
Retinal Detachments				
Trabeculectomy				
Treatment of eye infection				
Other (specify below)				

☐ **NONE OF THE ABOVE**

NO KNOWN CLAIMS DECLARATION

I declare that I am not aware of, nor do I, or any agent, employee, representative, or any other person(s) serving or acting on my behalf have any knowledge of, any claim, notice of claim, records request, letter of intent, incident, any unreported conduct, or any circumstance or occurrence which could reasonably be expected to result in a claim against me subsequent to the date of my signature below that I have not already reported to my previous professional liability carrier and which I have not disclosed on my application to Professional Underwriters Liability Insurance Company.

I have reported all claims, and all facts or circumstances that could give rise to a claim to appropriate prior carrier(s) and understand that all such known claims or potential claims will not be covered by this insurance. I also understand that this insurance does not apply to any of the following:

1. Any incident or claim for which I have received notice of a claim.
2. Any incident or claim for which a legal action has been filed against my employees or me.
3. Any incident or claim upon which any companies previously insuring me have previously established a claim file.
4. Any incident or claim arising out of any fact, circumstance, or situation indicating the possibility of a claim which was known to me as of the effective date of insurance for which I am applying.

Signature: **X** _____ Date: ____/____/____

_____
Print Name

WARRANTY & RELEASE

I do hereby warrant the truth of all statements and answers mentioned herein, and that I have not withheld any information which may influence or would influence the judgement of the Company in considering this application for professional liability insurance.

I understand that if the information in this application materially changes between the date of this application and the policy effective date, I will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

I understand and agree that erroneous and/or material misrepresentations or omissions will cause immediate rescission of my insurance coverage.

I understand and agree that the Company will not provide defense or indemnity coverage for any claims, civil lawsuits, arbitration, legal or administrative proceedings, incidents, accidents, or events in which damages or liability is assumed or imposed, or sought to be imposed, upon an insured under a written or oral agreement, specifically including a "hold harmless" indemnification or similar agreement, where the damages or liability assumed by, imposed or sought to be imposed are greater than that which would exist in the absence of such an agreement.

This application form, duly completed, together with any supplementary information, **must** be signed and dated in ink by the applicant. Signature of the form does not bind the applicant or the Company to issue coverage.

Signature: **X** _____ Date: ____/____/____

I understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, preceptorship, residency program, insurance company, underwriter and insurance agent/broker to furnish any information concerning me or my medical practice which the Company or its representative may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction, together with the agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even if the information is wrong.

Signature: **X** _____ Date: ____/____/____

CLAIMS INFORMATION FORM

CLAIM INFORMATION - Please type or print clearly

1. Name of Patient:_____ 2. Age:_____ 3. Sex:_____
4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon):_____
5. Allegation(s) (as stated by patient/plaintiff):_____
6. Date of Incident:_____ 7. Date Reported to Carrier:_____ 8. Location:_____
9. Insurance Carrier(s):_____
10. Other Defendants:_____
11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES ☐ NO ☐
12. Present Status: _____Incident Only _____Pending Suit _____Closed
    Date Closed:_____ Amount Paid:_____ Settlement or Judgment (circle one)
13. Condition and diagnosis at time of treatment:_____
14. Dates and description of treatment rendered:_____
15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT):_____
16. Defense Counsel:_____
17. Plaintiff's Counsel:_____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X**_____ Date:_____/_____/_____

CLAIMS INFORMATION FORM
(Please make additional copies if needed)

CLAIM INFORMATION - Please type or print clearly

1. Name of Patient:_____ 2. Age:_____ 3. Sex:_____
4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon):_____
5. Allegation(s) (as stated by patient/plaintiff):_____
6. Date of Incident:_____ 7. Date Reported to Carrier:_____ 8. Location:_____
9. Insurance Carrier(s):_____
10. Other Defendants:_____
11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES ☐ NO ☐
12. Present Status: _____Incident Only _____Pending Suit _____Closed
    Date Closed:_____ Amount Paid:_____ Settlement or Judgment (circle one)
13. Condition and diagnosis at time of treatment:_____
14. Dates and description of treatment rendered:_____
15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT):_____
16. Defense Counsel:_____
17. Plaintiff's Counsel:_____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X**_____ Date:____/____/____

NOTICE:

The underwriter is authorized to make any inquiry in connection with this application. The underwriter's acceptance of this application or the making of any subsequent inquiry does not bind the applicant or the underwriter to complete the insurance or issue a policy.

If the information in this application materially changes between the date of this application and the policy effective date, the applicant will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

Colorado Applicants: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other 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.

Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Missouri Applicants: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines civil and criminal penalties.

Ohio Applicants: Any person who, with intent to defraud or knowing that he 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.

Oklahoma Applicants: 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.

Pennsylvania Applicants: 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 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 such person to criminal and civil penalties.

Tennessee Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.