

- | | | | | | |
|--|-----------|------------|---|-----------|------------|
| | NO | YES | | NO | YES |
| 13. Do you possess or use radioactive materials?
If yes, please describe materials used: | | | Diagnostic purposes?
Therapeutic purposes? | | |
| | NO | YES | | | |
| 14. Do you perform surgery for obesity (intestinal bypass)? | | | | | |
| 15. (a) Do you perform surgery in your office?
(b) Do you perform surgery in any other non-hospital facility? | | | (c) Is general anesthesia administered
1. By you?
2. By others? | NO | YES |
| If yes, list and describe facilities where surgery is performed: | | | | | |
| (d) List the surgical procedures you perform in your office or other non-hospital facility: | | | | | |

Supplemental Questions

16. In order to properly classify your practice, please answer "YES" or "NO" as to whether you perform or desire to perform the following procedures:

- | | | | | | |
|--|-----------|------------|---|-----------|------------|
| A. MEDICINE: | NO | YES | F. ANESTHESIOLOGY: | NO | YES |
| Arterial Catheterization | | | Local | | |
| Liver Biopsy | | | Digital Block | | |
| CCU Care other than admitting privileges | | | Peripheral Nerve Block | | |
| Elective Cardioversion | | | Obstetrical Anesthesia | | |
| Peritoneal Dialysis | | | IV Anesthesia | | |
| | | | Spinal Anesthesia | | |
| | | | Pain Block | | |
| B. PEDIATRICS: | NO | YES | G. SURGERY: | NO | YES |
| Circumcisions | | | Minor Office Surgery | | |
| Treating critically ill infants and children | | | Aspiration of Cyst of Breast | | |
| Umbilical Catheterization & Monitoring | | | Repair of Laceration not
involving nerve or tendon | | |
| Exchange Transfusions | | | Assisting in Any Surgical Procedures | | |
| Neonatology (treating critically ill neonates) | | | Hernioplasties | | |
| | | | Appendectomies | | |
| C. OBSTETRICS: | NO | YES | Hemorrhoidectomies | | |
| Normal deliveries | | | Breast Biopsies | | |
| Episiotomy | | | Vein Stripping | | |
| Managing Toxemia | | | Anal Fissure | | |
| Low forceps | | | Adenoidectomy | | |
| Cesarean Sections | | | Tonsillectomy | | |
| Mid forceps | | | Nasal Polypectomy | | |
| Amniocentesis - Third trimester only | | | Cholecystectomies | | |
| Breech Delivery | | | Mastectomies | | |
| | | | Scalene Node Biopsy | | |
| D. GYNECOLOGY: | NO | YES | Anal Fistulectomies | | |
| Office Gynecology | | | Surgical Weight Reduction | | |
| Endometrial Biopsy | | | H. ORTHOPEDICS: | NO | YES |
| Cervical Biopsy | | | Injection of Bursa | | |
| Cervical Cautery | | | Repair of Extensor Tendon | | |
| Culdocentesis | | | Repair of Flexor Tendon | | |
| Dilation & Curettage | | | Any Operative Orthopedics | | |
| Cold Conization Cervix | | | Open Reduction of Fractures | | |
| Tubal Ligation | | | | | |
| Salpingectomy | | | I. EYE: | NO | YES |
| Oophorectomy | | | Refractions | | |
| A&P repair | | | Treatment of Eye Infection | | |
| Hysterectomy | | | Removal of Eyelid Lesions | | |
| Vaginal | | | Radial Keratotomy (RK) | | |
| Abdominal | | | Photorefractive Keratotomy (PRK) | | |
| Ectopic Pregnancy | | | Hexagonal Keratotomy (HK) | | |
| Laparoscopy | | | Excimer Laser Keratotomy | | |
| | | | Automated Lamellar Keratotomy (ALK) | | |
| E. UROLOGY: | NO | YES | Intraocular Lens Implant | | |
| Biopsy of Penile Lesions | | | | | |
| Aspiration of Hydrocele | | | | | |
| Circumcisions | | | | | |
| Orchidectomy | | | | | |
| Treatment of Torsion of the Testicle | | | | | |

17. Do you perform any of the following procedures which are defined as surgery?

As Surgeon
NO YES

As Assistant
NO YES

- (a) Any surgical procedures involving cutting into or within the abdominal cavity, chest cavity, orbital cavity, spine or facial sinuses?
- (b) Orthopedic surgery (other than orthopedic operations on the interphalangeal joints)?
- (c) Any amputations?
- (d) Plating, pinning or open reduction of fractures?
- (e) Mastectomy?
- (f) Plastic or cosmetic surgery?
- (g) Reconstructive vascular surgery, thromboembolectomy and thrombectomy of the arteries or veins?
- (h) Ophthalmic surgery?
- (i) Mastoidectomy?
- (j) Operations within the middle or inner ear?
- (k) Prostatectomy?
- (l) Submucous nasal resections?
- (m) Thyroidectomy?
- (n) Neurological surgery?
- (o) Any surgical procedures on malignant lesions except for diagnostic purposes?
- (p) Any cutting into or on the kidney, ureter or bladder?
- (q) Myringotomy?
- (r) Adenoidectomy?
- (s) Tonsillectomy?
- (t) Herniorrhaphy (inguinal or femoral only)?
- (u) Vasectomies and other procedures involving cutting into the scrotal sac?
- (v) Hemorrhoidectomies and other procedures limited to the anal ring?
- (w) The care and treatment of pregnancy (including labor, delivery and abortion but excluding cesarean section)?
- (x) Therapeutic abortion (1st trimester only)? # per month
- (y) Therapeutic abortion (after 12 weeks)? # per month
- (z) Injection treatment of varicose veins?
- (aa) Orthopedic operations of the interphalangeal joints?
- (bb) Abdominal surgery limited to appendectomies?
- (cc) Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)

As Surgeon
NO YES

As Assistant
NO YES

18. Indicate below any other procedures that you perform which are commonly considered to be surgery:

19. Do you perform laparoscopic cholecystectomies?
 If yes, describe training below. (Attach separate sheet if necessary.)

20. Do you perform the following procedures? (check either NO or YES)

NO YES

- (a) Venography
- (b) Amniocentesis
- (c) Arteriography (explain type)
- (d) Bronchoscopy
- (e) By-pass Monitoring
- (f) Chemotherapy
- (g) Colonoscopy
- (h) Cryosurgery
- (i) Dermabrasion
- (j) Endoscopy (explain type)
- (k) Hypnosis
- (l) Insertion of IUD
- (m) Laser therapy (explain)
- (n) Myelography
- (o) Needle Biopsy (explain type)
- (p) Organ transplants (explain type)
- (q) Acupuncture

NO YES

- (r) Paracentesis
- (s) Polypectomy by endoscopy
- (t) Dialysis Procedures
- (u) Thoracentesis
- (v) Gastric Bubble Insertion
- (w) Catheterization-arterial or cardiac
- (x) Convulsive shock therapy
- (y) Lymphangiography
- (z) Chelation therapy (explain)
- (aa) Arthroscopy or arthrography
- (bb) Peripheral nerve surgery
- (cc) FDA approved experiments (explain)
- (dd) Sex change (explain)
- (ee) Chymo-Papain Injections
- (ff) IVP
- (gg) Home or non-hospital deliveries (explain)
- (hh) Norplant Contraceptive

EXPLANATION:

21. Do you perform any of the following?

NO YES

- (a) Surgical treatment of cysts, superficial abscesses, minor traumatic wounds and superficial biopsies?
- (b) Biopsy procedures of lesions of the skin, and the mucous membranes of the mouth, nose, throat, vagina, uterine cervix and rectum?
- (c) Biopsy excision of lymph nodes?

SPECIALISTS

22. ANESTHESIOLOGISTS:

- | | NO | YES | | |
|---|----|-----|---|---------------|
| (a) Do you practice medicine or surgery other than anesthesia? | | | Percent of Patient's | % |
| (b) Describe other medicine or surgery performed: | | | | |
| (c) Do you employ or have you assumed supervisory duties over : | | | | NO YES |
| | | | 1. Any nurse anesthetists
2. Any inhalation therapists | |
| If yes, explain | | | | |

23. DERMATOLOGISTS:

- | | | | | |
|---|--|--|--|---------------|
| (a) Do you perform superficial X-ray therapy? | | | | NO YES |
| (b) Do you perform cosmetic surgery? | | | | |
| If yes, explain | | | | |

24. OBSTETRICIANS AND GYNECOLOGISTS:

- | | | | | |
|--|--|--|--|---------------|
| (a) Do you limit your practice to gynecology only? | | | | NO YES |
| (b) Do you employ or contract with, or cover for midwives? | | | | |
| (c) Do you do home or non-hospital deliveries? | | | | |

25. OPHTHALMOLOGISTS:

- | | | | | |
|--|--|--|--|---------------|
| (a) Do you practice Otorhinolaryngology? | | | | NO YES |
| (b) Do you perform cosmetic surgery? | | | | |
| If yes, explain | | | | |

26. OTOLARYNGOLOGISTS:

- | | | | | |
|---|--|--|--|---------------|
| (a) Do you practice ophthalmic surgery? | | | | NO YES |
| (b) Do you perform cosmetic surgery? | | | | |
| If yes, explain | | | | |

27. PEDIATRICS-NEONATOLOGY:

- | | | | | |
|---|--|--|--|---|
| (a) Percentage of your practice derived from neonatology?
(i.e., the treatment of critically ill neonates) | | | | % |
|---|--|--|--|---|

28. CRITICAL CARE, EMERGENCY ROOM, OCCUPATIONAL MEDICINE OR INDUSTRIAL MEDICINE:

- | | | | | |
|---|--|--|----|--|
| (a) Are you a critical care specialist? | | | | |
| (b) Are you an emergency room specialist? | | | | |
| (c) Are you an occupational medicine specialist (evaluation only)? | | | | |
| (d) Are you an industrial medicine specialist (diagnosis & treatment)? | | | | |
| (e) Are you providing or subject to providing care in an outside facility? | | | | |
| (f) If yes, give facility's full name, location and department in which you serve: | | | | |
| | | | | |
| (g) Is insurance coverage provided for your work by this facility? | | | | |
| (h) Is your work at this facility: | | | | |
| 1. On your own patients only? | | | | |
| 2. Required for staff privileges? | | | | |
| 3. Other? | | | | |
| 4. Percentage of gross income obtained from this care | | | %. | |
| (i) Is there a written contract or agreement to provide this service?
If yes, submit copy of written contract. | | | | |

SPECIALISTS (continued)

29. GENERAL SURGEONS, THORACIC SURGEONS, VASCULAR SURGEONS:

- | | | | | |
|---|--|---|--|---|
| <p>(a) Do you perform organ transplants?
If yes, what types?</p> <p>(b) Do you perform any surgery that is categorized as:</p> <p style="margin-left: 40px;">1. Orthopedic Surgery?
If yes, please complete section 31.</p> | <p>NO</p> <p>NO</p> <p>NO</p> | <p>YES</p> <p>YES</p> <p>YES</p> | <p>NO</p> <p>NO</p> <p>NO</p> | <p>YES</p> <p>YES</p> <p>YES</p> |
| <p style="margin-left: 40px;">2. Neurosurgery?
If yes, please complete section 31.</p> | | | | |

30. UROLOGISTS:

- | | | |
|--|------------------|-------------------|
| <p>(a) Do you perform prosthetic implants?</p> <p>(b) Do you perform organ transplants?</p> <p>(c) Do you perform sex changes?</p> <p>(d) Do you perform Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)
If yes, explain</p> | <p>NO</p> | <p>YES</p> |
|--|------------------|-------------------|

31. ORTHOPEDIC OR NEUROLOGICAL SURGERY:

- | | | |
|--|------------------|-------------------|
| <p>(a) Do you assume primary care in major spinal trauma?</p> <p>(b) Do you perform insertion of Pedicle Screws?
Number performed annually?</p> <p>(c) Do you perform lumbar laminectomies?
Number performed annually?</p> <p>(d) Do you perform cervical laminectomies?
Number performed annually?</p> <p>(e) Do you perform spinal fusions?
Number performed annually?</p> <p>(f) Do you perform anterior cervical discectomies?
Number performed annually?</p> <p>(g) Do you perform joint implants?</p> <p>(h) Do you perform scoliosis surgery?</p> <p>(i) Do you perform neuro implant surgery for pain?</p> <p>(j) Do you perform stereotactic neurosurgery?
Describe special training or experience in spinal surgery:</p> | <p>NO</p> | <p>YES</p> |
|--|------------------|-------------------|

PRACTICE

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

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

PRACTICE (continued)

33. What is your average weekly patient load?

34. Do you or your professional entity employ or contract for the service of any health care personnel in the following categories? Give the number of each:

	Number Employed	Number Contracted
(a) Nurses		
(b) Technicians		
(c) Psychologists		
(d) Physical Therapists		
(e) Physician's Assistants*		
(f) Nurse Practitioners*		
(g) CRNA's*		
(h) Nurse Midwives*		
(i) Other:		

*If yes, submit written explanation of practice and procedures performed, along with certificate of course completion and license number.

35. List hospitals at which you are currently a staff member and show percentage of work in each hospital:

- (a)
- (b)
- (c)
- (d)
- (e)

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

NO YES

- (a) Any health care facility having bed and board accommodations?
- (b) Any clinic, foundation, blood bank or laboratory?
- (c) Any health maintenance organization (HMO), preferred provided organization (PPO), individual physicians' association (IPA), and/or any pre-paid health plan, etc.?
If yes,
 1. Give full legal names and location of facility as well as any department in which you serve:

2. Is insurance coverage provided for this work by the above facility?

3. Are you:
- | | |
|--|---|
| (a) Owner (whole or part) | (b) Executive Officer (e.g. Board Member) |
| (c) Physician with teaching responsibilities | (d) Administrator (e) Director of Ancillary Services Department |
| (f) Committee Member | (g) Other, (describe) |

4. How are you compensated for your services? (a) Salary (b) Percentage (c) Fee for Service (d) Honorary or non-paid

5. Indicate which type of contractual agreement: (a) Oral (b) Written

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

37. **REMARKS** (Please indicate question number(s) referred to in the following remarks):

38. List additional medical specialty training:

TYPE

DATES

39. List malpractice coverage for the past 10 years:

NAME OF INSURER	DATES COVERED FROM - TO	LIMITS OF LIABILITY	Number of Pending Claims	Number of Closed Claims	Total Number of Claims
A					
B					
C					
D					

(PLEASE ATTACH A COPY OF YOUR MOST RECENT POLICY.)

NOTE: 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.

NO YES

- (1) Do you intend to purchase a reporting endorsement (a.k.a. Tail Coverage) from your current insurer?
- (2) If answer to (1) is NO, do you wish to obtain Prior Acts Coverage from us? NOTE: The offering of Prior Acts Coverage is subject to Underwriter approval.
- (3) If answer to (2) is YES, please attach a copy of your present insurance policy and complete the following:
 - (a) Applicant is/is not (**circle one**) as of this date aware of any CLAIMS or INCIDENTS against him/her that have not been reported to his/her present or prior insurer(s). Please Initial:
 - (b) Applicant is/is not (**circle one**) as of this date aware of any conduct, circumstances or incidents which occurred during the periods of coverage above that could reasonably be expected to result in a CLAIM or SUIT, which have not been reported to his/her present or prior insurer(s). Please Initial:
 - (c) Has your practice (e.g. specialty, procedures) changed in the last five years?
If YES, please explain:

NOTE: If you do not purchase Prior Acts Coverage from us you will not have any coverage through us for any claim, suit or incident based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued.

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

The Company policy does 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 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 though 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. Present Status: Incident Only Pending Suit Closed

Date Closed: _____ Amount Paid: _____ Settlement or Judgment (circle one)

12. Condition and diagnosis at time of treatment: _____

13. Dates and description of treatment rendered: _____

14. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): _____

15. Defense Counsel: _____

16. 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
(If more than one claim, please make copies)**

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. Present Status: _____ Incident Only _____ Pending Suit _____ Closed _____

Date Closed: _____ Amount Paid: _____ Settlement or Judgment (circle one)

12. Condition and diagnosis at time of treatment: _____

13. Dates and description of treatment rendered: _____

14. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): _____

15. Defense Counsel: _____

16. Plaintiff's Counsel: _____

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

Signature: **X** _____

Date: _____ / _____ / _____

NO KNOWN CLAIMS DECLARATION

I declare that I am not aware of, nor do I have any knowledge of, any claim or 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 which 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 a claim file has been previously established by any companies previously insuring me.
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.

Signed: _____ Date: _____
Applicant's Signature

Print Name

State of

County of

Supplemental information:

(please reference any questions you are referring to)