APPLICATION FOR PHYSICIANS AND SURGEONS AS EMPLOYED OR INDEPENDENT CONTRACTORS (OF SPECIFIED ENTITIES) PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made applies only to "Claims" first made during the "Policy Period." The limits of liability shall be reduced by "Claim Expenses" and "Claim Expenses" shall be applied against the deductible. Please read the policy carefully.

GENERAL INFORMATION

1. a. Full name of applicant: _____
   b. Legal operating name: _____
   c. Professional degree: _____
   d. Attach a copy of your letterhead and resume.
   e. Are you applying for coverage as an independent contractor? ☐ Yes ☐ No
   f. Are you applying for coverage as an employed physician ? ☐ Yes ☐ No
   g. Principal address where services as an independent contractor or employed physician are to be performed:
   Street address: _____
   City: _____ State: _____ County: _____ ZIP: _____
   h. Name of entity at this location for which coverage as an independent contractor or employed physician is being sought?
   _____
   If more than one location, attach a list on a separate sheet.
2. Average number of hours you practice each week: _____
3. What is your approximate gross annual income from your practice as an independent contractor or employed physician? $ _____

LICENSE INFORMATION

1. Provide the following information for all of the states in which you practice:

State	License Number	Effective Date	Expiration Date	Active?
				☐ Yes ☐ No
				☐ Yes ☐ No

2. Federal DEA License Number and status: _____

EDUCATION AND TRAINING

1. What is your medical or surgical specialty? _____
2. Are you American Board certified? ☐ Yes ☐ No
   If yes, what is the medical specialty in which you are certified? _____
3. Name of medical training institution: _____
   City: _____ State: _____ Date completed: _____

SCOPE OF PRACTICE AS INDEPENDENT CONTRACTOR OR EMPLOYED PHYSICIAN

1. Do you perform surgery, other than incision of boils and superficial abscesses or suturing skin and superficial fascia? ☐ Yes ☐ No
   If yes, complete the following checklist.

2. Check all procedures you perform, and indicate where each procedure is performed (**O** = Office or clinic *or* **S** = Surgical center):

☐ Abortions	☐ O	☐ S
☐ Acupuncture	☐ O	☐ S
☐ Adenoidectomy/Tonsillectomy	☐ O	☐ S
Anesthesia – Non-obstetrical:		
☐ General	☐ O	☐ S
☐ Spinal	☐ O	☐ S
☐ Epidural	☐ O	☐ S
☐ Other (describe):	☐ O	☐ S
☐ Angiography	☐ O	☐ S
☐ Angioplasty	☐ O	☐ S
☐ Anti-aging procedures – other than use of human growth hormone (describe):	☐ O	☐ S
☐ Arteriography	☐ O	☐ S
☐ Assisting in Surgery – on own patients or the patients of others	☐ O	☐ S
☐ Bariatrics	☐ O	☐ S
☐ Breast Implants	☐ O	☐ S
☐ Breast Reductions	☐ O	☐ S
☐ Catheterization – other than umbilical cord, urethral or arterial line in a peripheral vessel	☐ O	☐ S
☐ Chiropractic Manipulation	☐ O	☐ S
☐ Cryosurgery – other than on benign or pre-malignant dermatological lesions	☐ O	☐ S
☐ Chelation Therapy	☐ O	☐ S
☐ Dermabrasion/Chemical Peels	☐ O	☐ S
☐ Dilation and Curettage	☐ O	☐ S
☐ Discograms	☐ O	☐ S
☐ Electroconvulsive Therapy	☐ O	☐ S
☐ Erectile Dysfunction Therapy	☐ O	☐ S
☐ Endoscopic procedures	☐ O	☐ S
☐ Hair Transplants or Suturing of Hairpieces	☐ O	☐ S
☐ Herbal Medicine	☐ O	☐ S
☐ Homeopathy	☐ O	☐ S

☐ Hyperbaric Medicine	☐ O	☐ S
☐ Hysterectomies	☐ O	☐ S
☐ Laser skin resurfacing	☐ O	☐ S
☐ Laser Surgery (describe):	☐ O	☐ S
☐ Lymphangiography	☐ O	☐ S
☐ Mesotherapy	☐ O	☐ S
☐ Minimally invasive surgery (describe):	☐ O	☐ S
☐ Myelography	☐ O	☐ S
☐ Needle biopsies (describe):	☐ O	☐ S
☐ Obstetrics and Obstetric Care	☐ O	☐ S
☐ Open Reduction of Fractures	☐ O	☐ S
☐ Osteopathic Manipulation	☐ O	☐ S
☐ Pain Management (describe):	☐ O	☐ S
Plastic Surgery:		
☐ Silicone implants	☐ O	☐ S
☐ Silicone injections	☐ O	☐ S
☐ Pneumoencephalography	☐ O	☐ S
☐ Prolotherapy/proliterative therapy	☐ O	☐ S
☐ Radiation Therapy	☐ O	☐ S
☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	☐ O	☐ S
☐ Refractive surgery: LASIK, PRK, AK, PTK, ICR	☐ O	☐ S
☐ Sex reassignment/sex change surgery	☐ O	☐ S
☐ Silicone injection	☐ O	☐ S
☐ Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy)	☐ O	☐ S
☐ Temporomandibular Joint Dysfunction	☐ O	☐ S
☐ Trans Myocardial Laser procedures	☐ O	☐ S
☐ Weight Reduction	☐ O	☐ S
☐ Other (describe):	☐ O	☐ S

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3. Is general anesthesia administered for any of the procedures identified in questions 1 or 2 above? ☐ Yes ☐ No
   If yes, is anesthesia is administered by:
   a. You? ☐ Yes ☐ No
   b. An anesthesiologist? ☐ Yes ☐ No
   c. A Certified Registered Nurse Anesthetist (CRNA)? ☐ Yes ☐ No
      i. **If yes,** is the CRNA directed by or responsible to an anesthesiologist? ☐ Yes ☐ No
      ii. **If no,** explain the type of surgery and percentage of your surgeries or average number of such cases per month:
   d. Do you adhere to Harvard Standards for the administration of all anesthesia? ☐ Yes ☐ No
4. Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? ☐ Yes ☐ No
5. Do you:
   a. Dispense prescription drugs? ☐ Yes ☐ No
      If yes, are you a registered dispensing practitioner? ☐ Yes ☐ No
   b. Prescribe drugs via the internet? ☐ Yes ☐ No
      If yes, provide details:
   c. Provide diagnosis via the internet? ☐ Yes ☐ No
      If yes, provide details:
6. Indicate the number of professional employees you employ or supervise for each of the following. **If none,** check here: ☐
   Physicians other than yourself: _____ Podiatrists: _____ Chiropractors: _____ Optometrists: _____
   Physician's Assistants*: _____ Nurse Midwives*: _____ Nurse Anesthetists*: _____ Psychologists: _____
   Surgeon's Assistants*: _____ Nurse Practitioners*: _____ Other (describe): _____
   *Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.
7. Do you anticipate any changes in your work as an independent contractor or employed physician in the next year? ☐ Yes ☐ No
   If yes, attach a detailed explanation.

AFFILIATIONS

1. Are you in the employ of or under contract to any individual, firm or corporation other than the facility named in question 1.h? ☐ Yes ☐ No
   If yes, provide a detailed explanation including a description of your responsibilities:
2. Are you in the employ of or under contract to any governmental entity? ☐ Yes ☐ No
   If yes, provide a detailed explanation including a description of your responsibilities:

CLAIM HISTORY

1. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Insurance Company	Limits of Liability	Premium	Effective Date	Expiration Date	Claims Made **OR** Occurrence Form?	Retroactive Date

2. Has any claim or suit for malpractice ever been made against you? ☐ Yes ☐ No
   If yes, a. How many? _____
   b. Complete a copy of our Supplemental Claim form for each one.
3. Has any claim or suit for malpractice ever been made against you that has not been reported to the current insurer or any prior insurer?
   ☐ Yes ☐ No
   If yes, a. How many? _____
   b. Complete a copy of our Supplemental Claim form for each one.
4. Are you aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?
   ☐ Yes ☐ No
   If yes, a. How many? _____
   b. Complete a copy of our Supplemental Claim form for each one.
5. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non.renew or revoke your privileges? ☐ Yes ☐ No
6. Has 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? ☐ Yes ☐ No
7. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? ☐ Yes ☐ No
8. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? ☐ Yes ☐ No
9. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? ☐ Yes ☐ No

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 any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating there from shall be excluded from coverage under the proposed insurance.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____

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