231 South Bemiston, Suite 1000 St. Louis, MO 63105
Email: submissions@galeninsurance.com

ALLIED PROFESSIONAL NEW BUSINESS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE COVERAGE

INFORMATION REQUIRED – CHECKLIST

Please submit the following, along with the other information requested in this application:

1. Copy of all licenses and /or certifications
2. Curriculum Vitae
3. Most recent certificates for completion (attendance) for continuing medical education programs
4. Authorization for release of information (page 8 of the application) signed by applicant
5. Completed Form A Claim/Incident Report (page 7 of the application) for all claims, suits, and incidents in the past 10 years. (If none, then mark "NONE" and sign)
6. Copy of current Insurance Declarations page

INSTRUCTIONS TO APPLICANT

1. Answer all questions; if a question is not applicable, state "N/A", *PLEASE TYPE OR PRINT LEGIBLY*
2. If space is insufficient to answer any question fully, please use the Comments Section, (page 6 of the application), or attach a separate sheet
3. The application must be signed and dated by the applicant
4. If the answer to any question is none, state "None"
5. Application must be signed within 60 days of proposed effective date to bind coverage

IMPORTANT INFORMATION THIS DOCUMENT IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

Insurance coverage will not be considered until this application is completed, signed and dated. Failure to provide complete information and attachments as requested will cause delay. Completion of this form, with or without payment of premium, does not bind Galen Insurance Company ("Company", or "we" or "us") to issue insurance.

A policy of insurance is issued in reliance of the Applicant's complete and truthful information, provided in this application. False, misleading, omitting or concealing of fact, and/or any material misrepresentation of any information provided by the Applicant may result in rendering any policy of insurance, issued by Galen Insurance Company, null and void.

This document is an application for a claims-made policy of professional liability insurance. If issued, coverage under the policy is limited to liability for those claims that: (a) arise from incidents or events that happen while coverage under the policy is in force and that involve a named insured's professional services; and (b) are first made against a named insured and are reported to the Company during the policy period, including any extended reporting period, or during any optional extended reporting period provided through an endorsement.

INSURANCE COVERAGE IS SUBJECT TO UNDERWRITING APPROVAL, AND FULL PAYMENT OF THE PREMIUM. NO COVERAGE EXISTS UNTIL THE PREMIUM IS FULLY PAID AS AGREED AND A DECLARATION PAGE, TOGETHER WITH ANY ENDORSEMENTS THAT MAY APPLY, HAS BEEN ISSUED TO THE POLICYHOLDER.

For Agent's Use Only

Agent's Name	Agency Name
Date	Phone

GALEN INSURANCE COMPANY

231 South Bemiston, Suite 1000, St. Louis, MO 63105
Email: submissions@galeninsurance.com

ALLIED PROFESSIONAL NEW BUSINESS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
CLAIMS MADE COVERAGE

1. APPLICANT INFORMATION

a. Full Name:_____
(Include all names by which you have been known, and dates during which the name was used)

b. Date of Birth:_____ SS#:_____ □ Male □ Female

c. Home Address:_____

d. Principal Office Address:_____ County:_____
_____ Phone:_____
Email:_____ Fax:_____

e. Mailing Address:_____
(All correspondence from Galen including billing will be sent to the principal office address unless otherwise noted)

f. Are you a U.S. Citizen? □ Yes □ No If no, what is your current status in the U.S. and current citizenship?

g. Are you in active military service? □ Yes □ No

2. COVERAGE REQUESTED

Requested Effective Date:_____ Retroactive Date:_____
Important: Declarations Page of your current policy must be attached if a retroactive date is requested.

Employer/Group/Entity name:_____

Limits of Liability: □ SHARED Limits with Employer/Group/Entity
□ $ 200,000 Per Claim, $ 600,000 Annual Aggregate
□ $ 500,000 Per Claim, $1,500,000 Annual Aggregate
□ $1,000,000Per Claim, $3,000,000 Annual Aggregate

OR

□ SEPARATE Limits with Employer/Group/Entity
□ $ 200,000 Per Claim, $ 600,000 Annual Aggregate
□ $ 500,000 Per Claim, $1,500,000 Annual Aggregate
□ $1,000,000Per Claim, $3,000,000 Annual Aggregate

a. Are you full or part time? _____ If part time, how many annual hours do you work?_____

b. Are you entering private practice for the first time? □ Yes □ No

c. Name of Supervising Physician:_____

d. Will you be performing activities that will be covered by another Professional Liability Policy? □ Yes □ No
If yes, please provide details:_____
_____

3. CURRENT PRACTICE

a. List all locations where you currently work.

Office/Institution/Hospital	Employee (E) Contractor (C) Supervisor (S)	County/State	Specialty Practice	# hours per week	# patients per week
	□ E □ C □ S				
	□ E □ C □ S				
	□ E □ C □ S				
	□ E □ C □ S				

b. Do you practice as: (Requesting coverage for this specialty) Check all that apply.

□ Aesthetician	□ Laboratory Technician	□ Massage Therapist
□ Nurse (RN, LPN)	□ Nurse Aides	□ Nurse Anesthetist – CRNA
□ Nurse Midwife – No Deliveries	□ Nurse Midwife – Deliveries	□ Nurse Practitioner
□ Occupational Therapist	□ Operating Room Technician	□ Ophthalmologic Technician
□ Optician	□ Optometrist	□ Paramedic/EMT
□ Perfusionist	□ Pharmacist	□ Physical Therapist
□ Physician Assistant	□ Respiratory Therapist	□ Scrub Nurse
□ Social Worker	□ Surgical Assistant	□ X-ray Technician
□ Other (Describe)		

c. Describe your practice including any procedures you perform:

_____

_____

4. EDUCATION

Institution Name and Address	Year of Completion	Degree or Certification Attained

5. LICENSURE

State	License/Certificate #	County	% of Practice

6. PRIOR PRACTICE HISTORY

List all places you have worked in the past five (5) years.

Office/Institution/Hospital	County/State	Specialty Practice	Dates – From/To

7. PRACTICE INFORMATION

a. Does your current practice involve the treatment of:

Nursing home residents?	□ Yes □ No	If yes, what %_____
Prison inmates?	□ Yes □ No	If yes, what %_____
Emergency room/department?	□ Yes □No	If yes, what %_____
Cosmetic Aesthetics Clinic, Medi-Spa, Office, Surgery center?	□ Yes □No	If yes, what %_____

b. Do you have any teaching responsibilities? □ Yes □ No If yes, what %_____

c. Do you employ or supervise any allied professionals? □ Yes □ No If yes, what %_____

d. Do you independently prescribe/order drugs without same day authorization from your supervising physician? □ Yes □ No

e. Have your practice specialties or procedures changed in the past five (5) years? □ Yes □ No
If yes, please explain. Additional space provided in the Comments Section of this application.

_____

f. Do you perform or assist in any:

Laser procedures, chemical peels, fillers, or injections?	□ Yes □ No	If yes, what %_____
Joint injections	□ Yes □ No	If yes, what %_____
Obstetrical Deliveries?	□ Yes □ No	If yes, annual #_____
Psychiatric shock therapy?	□ Yes □ No	If yes, what %_____
Radiation therapy and /or Chemotherapy?	□ Yes □ No	If yes, what %_____
Surgical procedures?	□ Yes □ No	If yes, what %_____

g. **Please list ALL surgical procedures performed (including minor surgery) in:**
□ Professional Office □ Hospital □ Non- hospital facility (If the answer to the question is none, state None)

_____

h. Is Anesthesia (other than topical or by means of local infiltration) administered by either yourself or others?
If yes, please provide details in the Comments Sections of this application or attach separate page. □ Yes □ No

i. Please indicate the approximate division of your patients among:

Bariatrics -Weight loss- diet/exercise/injections	%	Orthopedic	%
Cosmetic or Elective	%	Otolaryngology	%
Counseling	%	Pain Management	%
Communicable Diseases	%	Pediatric	%
Emergency Room/Department	%	Physical Rehabilitation	%
Family Planning	%	Psychiatric	%
General Medicine	%	Radiology	%
Geriatric	%	Research or Experimental	%
Gynecology	%	Substance Abuse	%
Holistic or Alternative Medicine	%	Surgical and/or Assisting	%
Hospice	%	Therapy (Describe)	%
Obstetrical **with** Pre-natal care/Deliveries	%	Urgent Care	%
Obstetrical **without** Pre-natal care/Deliveries	%	Other (Describe)	%

8. APPLICANT AFFILIATIONS

a. Do you have hospital privileges? If yes, please provide name of hospitals and type of privileges. □ Yes □ No

_____

b. Do you own or operate (wholly or in part) any business, practice, clinic, spa, facility or institution? □ Yes □ No
If yes, provide details in Comments Section.

c. Are you employed by or under contract by any individual, entity, or government entity other than already detailed in question 3 (a) above? If yes, please attach an explanation, describing details or your responsibilities. If your contract contains a hold-harmless agreement, a copy of the contract must be attached □ Yes □ No

9. INSURANCE HISTORY

Current Carrier	Type	Effective Date	Expiration Date	Retro (Prior Acts) Date	Limits of Insurance
	□ **Claims Made** □ **Occurrence**				

If you answer "Yes" to question 9. (a or b) please complete Form A Claim/Incident Report form for each incident.

a. Have you ever had a claim, suit or other action based on any alleged professional negligence brought against you, your employees or any professional association, corporation or partnership to which you belong to or have belonged or have you been accused of professional negligence? □ Yes □ No
If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage? □ Yes □ No

b. Do you have knowledge of any claims, potential claims, circumstances that could possibly result in claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim? □ Yes □ No
If yes, has this incident(s) been reported to a prior insurer? □ Yes □ No

10. PROFESSIONAL INFORMATION

If you answer "Yes" to any of the questions below within the past ten (10) years, provide a detailed explanation in the Comments Section of this application, or on a separate sheet of paper.

a. Have you ever been investigated, charged with, or convicted of a violation of a federal, state, or local law other than routine traffic offenses or is any such charge pending? □ Yes □ No

b. Has your professional license, license to prescribe or dispense narcotics, or certification ever been denied, restricted, suspended, revoked, surrendered, put on probation, or issued on a restricted basis? □ Yes □ No

c. Are you currently aware of any investigation being conducted which could impact your license? □ Yes □ No

d. Are you currently being, or have you ever sought treatment from any mental health or chemical/substance abuse program? □ Yes □ No

e. Have you ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? □ Yes □ No

f. Have you ever been investigated or had a complaint, claim or suit brought against you for alleged sexual misconduct? □ Yes □ No

g. Have you incurred, or become aware of having a condition that impairs your ability to practice your professional duties? *(e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics, or other controlled substances, etc.)* □ Yes □ No
If yes, please state condition and dates. In addition, , a statement from your physician attesting to your fitness to practice must accompany this application.
Type of Illness:_____ Dates From/To:_____

COMMENTS SECTION (use additional sheets as necessary)

Page Number	Question Number	Comment

Form A – Claim/Incident Report

Please complete for each suit, claim, or incident for which you responded yes in questions 9 a-b of the Insurance History.

1. Name of Patient:_____Age:_____Sex:_____

2. Your relationship to patient:_____
(e.g. Attending Physician, Primary Surgeon, Assistant Surgeon)

3. Type: □ Incident □ Request for records □ Demand for money or services □ Suit

4. Allegation(s) (as stated by patient/plaintiff):_____
_____

5. Date of Incident:_____ Date Notified:_____ Date Reported to Insurer:_____

6. Name of Insurer:_____

7. Location, State, and County of Incident:_____

8. Other Defendants involved:_____
(Physicians, Professionals or Entities)

9. Condition/diagnosis at time of Incident:_____
_____

10. Dates/description of treatment rendered:_____
_____

11. Condition of patient subsequent to treatment:_____
_____

12. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? □ Yes □ No

13. Status of claim:

□ Suit threatened, no action taken	□ Court outcome in your favor	□ Open – Status Pending
□ Suit filed but dropped by claimant	□ jury verdict	
□ Summary judgment in your favor	□ directed verdict	□ Awaiting mediation/arbitration
□ Settled out of Court	□ Court outcome in favor of plaintiff	□ Awaiting Court action
Date Claim paid:_____	□ jury verdict	Reserve Amount:$_____
Amount paid on your behalf: $_____	□ directed verdict verdict amount:$_____	

Did you wish settlement of the claim? □ Yes □ No

14. Name and address of the Attorney assigned to your case:_____

15. Name of Plaintiff's Attorney:_____

I understand this information becomes a part of my application for professional liability insurance.

Print Name:_____

Signature:_____ Date:_____

11. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

The undersigned applicant hereby represents to Galen Insurance Company (the "Company")that all statements and explanations contained in this application and all attachments are true, complete and accurate, and that the applicant has not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application for professional liability insurance. The applicant agrees to notify the Company of any change in the information contained in this application or any attachment if the change occurs while this application is under review or after coverage begins, if a policy is issued. The applicant further agrees to be bound by, and subject to, the underwriting guidelines, policies, and procedures of the Company.

The applicant acknowledges that he or she is responsible for payment of all unpaid premiums regardless of whether anyone has agreed to pay premiums on his or her behalf.

The applicant understands and acknowledges that upon acceptance of this application by the Company, this application will become a part of the policy and operate as part of a contract between the applicant and the Company. The applicant also understands and acknowledges that any misstatement or omission by the applicant or anyone for whom coverage is being sought, or any failure by the applicant or anyone for whom coverage is being sought to cooperate fully with Company will, in the discretion of the Company, result in the exclusion of a related claim from coverage under the policy and that under such circumstances the Company will not pay damages or claim expenses nor provide a defense to such a claim.

In addition, such misstatements or failure to cooperate may result in cancellation of the policy.

The applicant hereby affirms that he or she has completed the required reporting of incidents and claims to the applicant's current insurer.

I understand this information becomes a part of my application for professional liability insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned hereby authorizes Galen Insurance Company and its affiliates, agents, and representatives (the "Company") to make inquiries, investigate, and consult with all persons, places of employment, educational institutions, malpractice insurance carriers, state licensing boards, or other similar government and non-governmental entities or persons who may have information bearing on the undersigned's moral, ethical, and professional reputation and qualifications, training, and competence to carry out the practice of medicine. The undersigned authorizes release of such information and copies of related records and documents to the Company.

The undersigned releases from liability and holds harmless all persons who provide information to the Company in good faith and without malice in response to such investigations and inquiries, and releases from liability and holds harmless the Company for all information disclosed by the Company in good faith and without malice in making such investigations and inquiries.

The undersigned agrees that a photocopy or facsimile of this authorization will serve as if it were the original.

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FRAUD DISCLOSURE STATEMENT
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Print Name of Applicant:_____

Signature:_____ Date:_____

ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds? □ Yes □ No

If yes, please read and approve the following statement:

By my signature, I assign to the following employer or named third party (include name and address) both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-314-721-2377 or sending written notice to:

Galen Insurance Company
231 South Bemiston, Suite 1000
St. Louis, MO 63105

Name:_____

Street:_____

City:_____ State:_____ Zip:_____

_____ _____

Signature of Insured *Date*

PLEASE NOTE: YOUR RIGHT TO CANCEL AND RECEIVE A PREMIUM REFUND WILL AUTOMATICALLY BE ASSIGNED TO A THIRD PARTY FINANCE COMPANY IF IT PAYS YOUR PREMIUM ON YOUR BEHALF.