GALEN INSURANCE COMPANY

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

GROUP OR ENTITY APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

CLAIMS MADE COVERAGE

INFORMATION REQUIRED

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

- ☐ All medical staff bylaws applicable to the practice(s).
- ☐ If the Applicant is or is part of a partnership, joint venture, or limited liability company, all governing documents (e.g., partnership agreement, operating agreement, etc.).
- ☐ List all offices, facilities, physicians and allied professionals for whom coverage is sought showing their relationship to the entity (e.g., shareholder, employee, partner, or independent contractor).
- ☐ Signed and completed applications for all physicians and allied personnel for whom applications are required and coverage with separate limits is sought.
- ☐ Applicant's most recent financial statements and audited financial statements, if available.
- ☐ Loss runs for last 10 years, include the date of the event, date the claim was reported, a description of the loss, current status, reserve and paid amounts.
- ☐ All practice management agreements, management services agreements, and similar agreements.
- ☐ All agreements where other parties are indemnified.
- ☐ Applicant's letterhead and all advertisements in the past two years.

INSTRUCTIONS

1. Answer all questions; if a question is not applicable, state "N/A"
2. If space is insufficient to answer any question fully, please use the Comments Section, (page 7 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

For Agent's Use Only

Agent's Name	Agency Name
Date	Phone

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", "we", or "us") to issue insurance.

Processing Time

Please be advised that a minimum of 30 business days is required to process this application once it is received in our office. After this application has gone through our underwriting process, we will inform the Facility (called "Applicant" or "you" in this document) of our response to this application.

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.

Completion of Application

This application is for the use of a corporation, partnership, or medical group. Individual doctors and allied medical professionals affiliated with the group who are seeking separate insurance should complete the appropriate application for individuals.

All questions must be answered. For questions that do not apply to the Applicant's practice situation, please write "N/A" in the answer space provided. If the Applicant does not know the answer to a particular question, please note that in Part VII, the Comments Section, of this application. All questions should be answered based on the knowledge of the Applicant (including its employees, officers, directors, members, shareholders, partners, affiliates, or representatives) and all parties to be insured under the policy, if issued. All questions should be answered based on the information applicable to and regarding the Applicant and all affiliates, facilities, physicians, and allied professionals for whom coverage is being sought.

Please note the additional information (and related checklist) required and outlined in Part VI of this application. Please make certain that all required information and attachments are provided in order to assist us in processing this application promptly and efficiently.

If an explanation is required for any answer, please use Part VII, the Comments Section, of this application to provide the explanation. If additional space is necessary, attach separate, additional pages to this application.

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.

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GROUP OR ENTITY APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE COVERAGE

INSTRUCTIONS TO THE APPLICANT:

1. *Answer all questions fully and completely; PLEASE TYPE OR PRINT LEGIBLY,*
2. *If a question is not applicable, state "N/A"*
3. *If space is insufficient to answer any question fully, use page 15, the Comments Section, of this application, or attach a separate sheet*
4. *The application must be signed and dated by the applicant*

PART 1 - APPLICANT INFORMATION

1. Organization Name:_____

2. Federal Tax ID:_____ Date Established: _____

3. Primary Office Street Address:_____

4. City:_____ County:_____ State:_____ Zip:_____

5. Office Telephone:_____ Office Fax:_____

6. E-Mail Address:_____ Website Address: _____

7. P.O. Box Address:_____

8. Billing Address: *(If same as primary office address check here □)*
_____

9. Contact Name:_____ Title:_____

10. Type of Practice: Specialty:_____ Subspecialty:_____

11. Is this entity associated with a current Galen Insurance Company insured?
If yes, please provide name and policy #:_____

12. Number of Employees:_____ Total Annual Gross Receipts:_____

13. Applicant organizational structure and type (check all that apply):

□ General Corporation □ Individual □ Joint Venture
□ Limited Liability Company (LLC) □ Limited Liability Partnership (LLP) □ Partnership or Professional Association
□ Professional Corporation - sole shareholder □ Professional Corporation – Multiple shareholders
□ Not for Profit □ Profit
□ Other (describe) _____

14. Is any part of the Applicant's business operated or leased by a management company?..... ☐ Yes ☐ No
If yes, please give the name of the company and details of the structure and relationship on a separate sheet.

List all legal name(s) of the Applicant:_____
Other business names (e.g. DBA's):_____

15. List all affiliates:_____
Description of affiliate operations:_____
Identify affiliates for whom coverage is requested:_____

16. Has the Applicant or any affiliate ever filed for bankruptcy? ..... ☐ Yes ☐ No
If yes, when? _____ Chapter:_____

17. What was Applicant's payroll for the most recent 12 month period?_____
What were the Applicant's annual receipts for the most recent 12 month period?_____

18. Has the Applicant sold, acquired, or discontinued any operations in the past ten (10) years? ..... ☐ Yes ☐ No
If yes, please explain in Part VII, the Comments Section, of this application or on a separate attached sheet.

19. Is the Applicant considering any changes in operations, services, or products in the next 12 months? ..... ☐ Yes ☐ No
If yes, please explain in Part VII, the Comments Section, of this application or on a separate attached sheet.

PART 11 - COVERAGE REQUESTED

1. Requested Effective Date:_____ Requested Retroactive Date:_____

2. Limits of Liability: □ SEPARATE Limits
□ $ 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
□ SHARED Limits
□ $ 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

3. Deductible requested: ☐ Zero ☐ $5,000 ☐ $10,000 ☐ Other: $_____

4. Are the above limits requested higher than the Applicant's or a named insured's current coverage? ..... ☐ Yes ☐ No

5. Has the Applicant or any named insured ever applied to or been insured by the Company in the past? ..... ☐ Yes ☐ No

Individuals seeking separate limits must complete a separate application.

PART III – PRACTICE INFORMATION

1. Does Applicant own, operate, or manage a hospital, clinic, pharmacy, dispensary, laboratory or other medical facility?
☐ Yes ☐ No If yes, please describe:_____
If yes, please identify the insurer and limits?_____

2. Will the entity be performing activities which will be covered by another professional liability Policy?
If yes, state practice name, location and insurer name.
Practice name:_____
Location:_____
Name of Insurer:_____

3. Are credentials for physicians and allied professionals verified prior to joining the practice? ..... ☐ Yes ☐ No
4. Are all physicians' and allied professionals' privileges reviewed at least once every two years? ..... ☐ Yes ☐ No
5. Is there a probationary period? ..... ☐ Yes ☐ No
6. Are new physicians and allied professionals proctored? ..... ☐ Yes ☐ No
7. Do any physicians or allied professionals have a restricted license or privileges? ..... ☐ Yes ☐ No
8 Are all physicians or allied professionals required to maintain professional liability coverage? ..... ☐ Yes ☐ No
What limits? $_____
9. Are insurance certificates maintained by Applicant? ..... ☐ Yes ☐ No
10. Is there an ongoing quality assessment/improvement plan? ..... ☐ Yes ☐ No
11 Is there an ongoing risk management plan? ..... ☐ Yes ☐ No

12. List all office and facility locations:
    Name, Address and Usage:_____
    Name, Address and Usage:_____
    Name, Address and Usage:_____
    Name, Address and Usage:_____
    Name, Address and Usage:_____
13. Does Applicant have a contract with a practice management company, MSO, or similar entity? ..... ☐ Yes ☐ No
14. Are services rendered under any service contracts (e.g., managed care, medical directorships, etc.)? ..... ☐ Yes ☐ No
15. Does the Applicant own, operate, or control any specialized, medically-related unit, such as a pharmacy, laboratory, physician therapy center, free-standing surgery center, etc.? ..... ☐ Yes ☐ No
    If yes, please provide additional, detailed information in Part VII or on a separate sheet regarding the location, type of services provided, number of service providers at each location, and the relationship of that unit to the Applicant.

PART IV - PRIOR ACTS COVERAGE PERIOD

1. Does Applicant seek prior acts coverage? ☐ Yes ☐ No If yes, requested retroactive date: _____

2. List below the full names of **all** physicians who practiced with, or for the Applicant during the past ten years or over the period for which prior acts coverage is sought if that is less ("Prior Acts Coverage Period"). If any physician is no longer associated with the Applicant, indicate the period of association and whether tail coverage (extended reporting period coverage) was purchased. Attach additional sheets as needed.
   Note: Include all applicant(s), all healthcare provider(s), and non-healthcare owner(s).
   Column 5 Individual Status Key
   A. Requesting Individual coverage from Galen Insurance Company.
   B. Currently Individual Galen Insurance Company insured.
   C. Applying for coverage elsewhere or covered elsewhere.
   T. Terminated or No longer working for/with entity.

Physician Name	**Designation MD, DO, etc…**	**Specialty**	**(S) Shareholder (P) Partner (E) Employee (IC) Ind. Contractor**	**Individual Status A, B, C, or T See key above**	**Active dates From/To**	**Retroactive Date**	**If Terminated Was Tail Coverage Purchased**
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No

3. List below the full names of **all** allied professionals who practiced with, or for the Applicant during the Prior Acts Coverage Period. If any allied professional is no longer associated with the Applicant, indicate the period of association and whether tail coverage was purchased. Attach additional sheets as needed.
   Note: Include all applicant(s), all healthcare provider(s), and non-healthcare owner(s).
   Column 5 Individual Status Key
   A. Requesting Individual coverage from Galen Insurance Company.
   B. Currently Individual Galen Insurance Company insured.
   C. Applying for coverage elsewhere or covered elsewhere.
   T. Terminated or No longer working for/with entity.

Allied Professionals Name	**Designation PA, NP etc…**	**Specialty**	**(S) Shareholder (P) Partner (E) Employee (IC) Ind. Contractor**	**Individual Status A, B, C, or T See key above**	**Active dates From/To**	**Retroactive Date**	**If Terminated Was Tail Coverage Purchased**
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No

4. List all locations at which services have been rendered by, on behalf of, or for the Applicant during the Prior Acts Coverage Period. Attach additional sheets as needed.

Name of Practice:	Location:	From Mo/Yr - To Mo/Yr:

PART V - INSURANCE INFORMATION

1. Complete the following chart for **all** of the Applicant's professional liability insurers during the Prior Acts Coverage Period. Begin with the Applicant's most recent professional liability insurer.

Claims- Made or Occurrence	Year(s)	Insurance Carrier	Policy Number	Coverage Period From/To	Liability Limits Per Claim/Aggregate
				/	/
				/	/
				/	/
				/	/
				/	/

2. Has the Applicant ever been notified of its, his or her involvement in a malpractice claim, suit or incident, either directly or indirectly?. ……☐ Yes ☐ No

3. Are there any claims or suits threatened or pending against the Applicant or has there been any circumstance, occurrence, incident, or accident that is likely to give rise to a claim or suit that has not been reported to the Applicant's current or prior insurers? ……☐ Yes ☐ No

4. Are there any incidents (e.g., patient's expression of dissatisfaction or fee dispute) for which there is reason to believe may lead to a claim or suit against the Applicant? ……...☐ Yes ☐ No

5. Has any incident, claim or suit been reported to another insurer by any of the Applicant's current or former employees, shareholders, members, partners, or associates on their own behalf, which have not been reported on behalf of the Applicant?. …….☐ Yes ☐ No

6. Has any incident (which has not yet resulted in a claim or suit) been reported on behalf of the Applicant to another insurer?..... ☐ Yes ☐ No

7. Has the Applicant received any oral or written threats of legal action, attorney's request for patient records, subpoena, petition, complaint, summons, citation, or other legal process or notification?.....☐ Yes ☐ No

If any of the above Questions 2-7 above were answered yes, please provide complete detailed information regarding the matter in Part VI of this application or on a separate sheet.

NOTE: All incidents identified in response to Questions 2-7 should be reported to the Applicant's current insurer - doing so does not necessarily eliminate the need for tail coverage. **If the Applicant's current insurance is written on a claims-made form, it is necessary to purchase tail coverage from the Applicant's present insurer or nose coverage (prior acts coverage) from the Company to reduce the possibility of having a gap in coverage.**

8. Has the Applicant purchased or will the Applicant purchase tail coverage from its current insurer? …..……☐ Yes ☐ No
If no, is the Applicant requesting nose coverage from the Company?

9. List all states where Applicant is doing business.
_____
_____

10. Has the Applicant's prior insurance coverage ever included coverage for another person not already identified as part of this application? …… .☐ Yes ☐ No
If yes, please explain on a separate sheet and attach a copy of any endorsement(s) providing coverage for such individual (including locum tenens) or entity. Each is subject to separate underwriting consideration.

PART VI – COMMENTS SECTION (use additional sheets as necessary)

Page Number	Question Number	Comment

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

You hereby represent 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 you have not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application for professional liability insurance. The Facility 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.

Acceptance of advance payment does not bind the Company to provide insurance.

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

You understand and acknowledge 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 Facility also understands and acknowledges that any misstatement or omission by the Applicant or anyone for whom coverage is being sought, or any failure by you 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 Facility hereby affirms that it has completed the required reporting of incidents and claims to the Applicant's current insurer.

Print Facility (Proposed Policyholder) Name:_____

Signature _____ Date:_____
Print Signer's Name and Title:_____

Agent/Broker Signature (if any): _____ Date: _____
Print Agent/Broker Name:_____ License: _____

An underwriter may contact the Applicant for further information or clarification.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned for itself and for all affiliates and facilities for which insurance coverage is sought 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. The undersigned authorizes release of such information and copies of related records and documents to the Company.

The undersigned authorizes the Company to disclose to such persons, employers, institutions, boards, or agencies any information about the undersigned or its practice or business that the Company determines to be necessary or appropriate in making its investigations and inquiries.

The undersigned for itself and for all affiliates and facilities for which insurance coverage is sought 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.

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 Applicant (Proposed Policyholder) Name:_____

Signature _____ Date _____

Print Signer's Name and Title:_____