GALEN INSURANCE COMPANY

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

RENEWAL APPLICATION FOR PHYSICIANS AND ALLIED PROFESSIONALS
PROFESSIONAL LIABILITY INSURANCE
CLAIMS MADE COVERAGE

THIS DOCUMENT IS NOT A BINDER OR ACCEPTANCE OF INSURANCE.

- **The applicant must complete or personally supervise the completion of this application.**
- **Answer all questions; if a question is not applicable, state "N/A"**
- **If an explanation is required for any answer, please use Comments Section, or a separate sheet**
- **The application must be signed and dated by the applicant**
- **If the answer to any question is none, state "None"**
- **Application must be signed within 60 days of proposed effective date to bind coverage**

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.

Renewal Effective Date:_____ **Policy #:**_____

1. Insured's Name: _____
   (First) (Middle) (Last)
2. Practice Name: _____
3. Practice Address: _____
4. Practice Phone:_____ Email: _____
5. Practice Fax: _____ Website:_____
6. Office Contact:_____ Title:_____
7. Preferred Mailing Address:_____
8. What is your current medical specialty? _____

8. Are you board certified? ☐ Yes ☐ No If yes, what specialty: _____

9. DEA License Number: _____

10. Any new states added? Y N If yes list below:

State	License #	Status	Expiration

11. How many hours per week do you practice? _____

12. Has your practice changed during the past year? ☐ Yes ☐ No
    If yes, please note all changes in the Comments section.

13. Have you participated in CME's during the past year? ☐ Yes ☐ No
    If yes, how many hours?_____

14. Have you performed any new procedures during the past year? ☐ Yes ☐ No
    If yes, please note procedures on the Comments section.

15. Are you a Medical Director for any facility? ☐ Yes ☐ No
    If yes, do they provide your professional liability insurance? ☐ Yes ☐ No

16. During the past year, has any facility or organization limited or eliminated your privileges? If yes, please explain on the Comments section. ☐ Yes ☐ No

17. During the past year, have you been investigated, charged with, or convicted of a violation of a federal, state, or local law other than routine traffic offenses? ☐ Yes ☐ No
    If yes, please explain on the Comments section.

18. During the past year, have you become afflicted with any illness or physical condition that impairs or could impair your ability to practice medicine, including alcoholism, mental illness, or narcotics addiction? ☐ Yes ☐ No
    If yes, please explain on Comments section.

19. During the past year, have you become aware of any claim arising from professional services you rendered? If yes, please describe on the Comments section. ☐ Yes ☐ No

20. During the past year, has any existing claim with a previous professional liability insurance carrier been resolved? ☐ Yes ☐ No
    If yes, please provide a separate sheet with the details of the suit.

21. Have you had or are you aware of a claim, suit, or incident likely to become a medical malpractice claim? If yes, please describe on the Comments section. ☐ Yes ☐ No

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.

COMMENTS SECTION (use additional sheets as necessary)

Page Number	Question Number	Comment

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.

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

Print Name of Applicant:_____

Signature:_____ Date:_____

Authorization and Release of Liability to Provide Verification of Coverage and Claims History

I hereby consent to and authorize the release to any Hospital, PPO, Credentialing Agency, etc., by any representative of Galen Insurance Company, information and documents that may be relevant to a verification of my professional liability insurance and or claims history. I agree that any person or organization furnishing information pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information. This release is submitted as part of my application and will remain in effect until revoked by me in writing.

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

Applicant's 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.