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

MARYLAND

PHYSICIAN 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 Medical Licenses
2. Curriculum Vitae
3. Most recent certificates for completion (attendance) for continuing medical education programs
4. Authorization for release of information (page 17 of the application) signed by applicant
5. Completed Form A Claim/Incident Report (page 16 of the application) for all claims, suits, and incidents in the past 10 years. (If none, then mark "NONE" and sign)
6. 10 years of currently valued loss runs from all prior Insurance Companies
7. Copy of current Insurance Declarations page.
8. Copy of business letterhead

***Supplemental applications are required for physicians practicing:**
-Anesthesiology
-Bariatric Surgery
-Obstetrics
-Plastic

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 15 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", 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, and/or any material misrepresentation of any information provided by the Applicant may result in cancellation of the policy or a recalculated premium during the underwriting period. The insurance policy is subject to a 45 day underwriting period beginning on the effective date of coverage. Galen Insurance Company may cancel the policy within the underwriting period if the risk does not meet its underwriting standards provided notice of cancellation is sent to the insured at least 15 days prior to cancellation. If the Company discovers a material risk factor during the underwriting period, then the insurer shall recalculate the premium provided the risk continues to meet its underwriting standards and notice of the recalculated premium is sent to the insured.

Completion of Application

The applicant must complete or personally supervise the completion of this application. All questions must be answered. For questions that do not apply to your practice situation, please write "N/A" in the answer space provided. If you do not know the answer to a particular question, please note that in the answer space provided, or in the Comments Section, (page 15 of this application). All questions should be answered based on the knowledge of the applicant (including his or her employees, partners, or representatives) and all affiliates, facilities, physicians, and allied professionals 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 information required checklist outlined at the beginning of this application. 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 the Comments Section, (page 15 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.

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

PHYSICIAN NEW BUSINESS 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*

1. APPLICANT INFORMATION

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

b. Professional Designation: ☐ M.D. ☐ D.O. ☐ Other (Describe)____________________

c. Date of Birth:________________ SS#:____________________ ☐ Male ☐ Female
(Required)

d. Home Address:______________________________ Phone:________________
____

e. Principal Office Address:____________________________Office Contact:____________
______________________________________Title:________________

f. Phone:____________________ Email:______________________________
Fax: ____________________ Website:____________________________

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

h. Additional Practice Locations and Percentage of Practice at each: Phone:________________
____%______
____%______

i. Are you a U.S. Citizen? ☐ Yes ☐ No If No, what is your current status in the U.S. and current citizenship?
____

j. Are you in active military service? ☐ Yes ☐ No

k. Applicant is: (check all boxes that apply)

☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Professional Corporation
☐ Employed Physician of__________________ ☐ Independent Contractor of__________________
☐ Other (Describe) ____

l. Practice is a: □ Solo Practice □ Group Practice

m. Legal entity(ies) name:____
Federal Identification Number(s):________________________________ Applicant's % of ownership:___________
Number of years at this location:________________________________
How many other physicians practice at this entity:__________________

n. Please list name(s) of ALL other partners, stockholders, associates, independent contractors and employed physicians practicing at this entity and their current insurance carriers:
____
____
____

2. LICENSURE

State	License #	County	% of Practice
DEA License #:			

3. COVERAGE REQUESTED

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

b. Will you be the □ policyholder, or □ named insured on a group policy

c. Are you requesting that the legal entity in question m. above be named on your policy? □ Yes □ No
(If the carrier does not insure all the members, the coverage extended to the corporation would respond only to liability arising out of the acts of the insured physician).

d. Limits of Liability: □ SEPARATE Limits
$1,000,000 Per Claim, $3,000,000 Annual Aggregate
Other: $_______________ Per Claim, $_________________ Annual Aggregate
OR
□ SHARED Limits
$1,000,000 Per Claim, $3,000,000 Annual Aggregate
Other: $_______________ Per Claim, $_________________ Annual Aggregate

e. Deductible requested: □ Zero □ $25,000 □ $50,000 □ $100,000

f. What Specialty and/or Subspecialty are you requesting coverage for and % of practice:
Specialty:__________________________ %_________ Subspecialty:__________________________ %_________

g. Are you full or part time? _______________ If part time, how many annual hours do you work?_________________

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

4. EDUCATION

	Hospital/College	City/State/Country	Completed?	Dates-From/To
Medical School			□ Yes □ No	
Internship			□ Yes □ No	
Residency			□ Yes □ No	
Fellowship			□Yes □ No	
Other Training			□Yes □ No	

a. If you are a Foreign Medical School Graduate, are you ECFMG certified? □ Yes □ No
If no, please provide explanation in Comments Section

b. Are you currently American Board Certified? □ Yes □ No
If yes, please indicate which board and specialty/subspecialty:
□ American Board of __________________________ □ American Osteopathic Board of _______________________

c. If you are not American Board Certified, are you American Board Eligible? □ Yes □ No

d. Have you ever been refused board certification? □ Yes □ No
If yes, provide details in Comments Section.

e. Identify all medical and professional societies to which you belong: _______________________________________
____

f. Please indicate the total number of CME hours you have completed in the past two years:____________________

g. Have you completed Risk Management CME in the last two (2) years? □ Yes □ No

5. MEDICAL PRACTICE HISTORY

a. Within the last five (5) years have your practice specialties or procedures performed changed? □ Yes □ No
If yes, please provide complete details in the Comments Section of how the specialties or procedures have changed and give the dates of changes.

b. List all office locations where you have practiced in the last five (5) years, beginning with current practice.
(use Comments Section or separate page if needed)

Entity/Group/Practice Name	City/State	Specialty	Dates – From/To

c. Please explain any gaps in your training or practice, if not explained in your curriculum vitae:________________
____

6. HOSPITAL PRIVILEGES

a. Have your hospital privileges been expanded during the last 12 months to include procedures for which you completed additional training required by the State Licensing board and/or your Board Specialty? ☐ Yes ☐ No

b. List hospitals in which you have current staff membership or privileges.
(If no hospital privileges, please provide protocol for patient hospital admission in Comments Section)

Hospital	City/State	County	% of Practice	Type of Privilege

7. OFFICE STAFF

a. Do you employ, contract with, or supervise any Physician(s) or Surgeon(s) ☐ Yes ☐ No
If YES, enter information below.

Physician/Surgeon Name	Medical Specialty	Limits of Liability	Employ (E) Contract (C) Supervise (S)	Insurer
			☐ E ☐ C ☐ S	
			☐ E ☐ C ☐ S	
			☐ E ☐ C ☐ S	

b. Do you employ, contract with, or supervise any non-physician health care extenders? ☐ Yes ☐ No
If YES, enter information below.

Type	Number Employed	Number* Supervised Only	Type	Number Employed	Number* Supervised Only
Chiropractor			CRNA		
Medical Lab Technician			Message Therapist		
Midwife			Nurse (RN/LPN/LVN)		
Nurse Practitioner			Optometrist		
Pharmacist			Physical Therapist		
Physician Assistant			Surgeon Assistant		
X-Ray Technician			Other: Identify		

*If you supervise do you have a collaborative agreement? ☐ Yes ☐ No

8. PRACTICE INFORMATION

a. Please complete the following information regarding the patient volume of your practice (weekly average):
Number of patients seen by you in the office:……………………………… ____________per week
Number of patients seen by you in the hospital:……………………………. ____________per week
Number of patients seen only by paramedical personnel employed by you:. ____________per week
Walk-in patients………………………………………………………. ____________per week
Total……………………………….. ____________per week

b. Please indicate average number of hours per week that you spend in the following:
Office practice: ____________hours Emergency room: __________hours
Hospital practice: ___________hours On-Call: _________________hours

c. Check all appropriate boxes, indicating the extent of surgery you perform:

☐	**No Surgery**	No surgery with the exception of: suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue). Localized treatment of second and third degree burns and umbilical and urethral catheterization.
☐	**Minor Surgery**	**#Annually:____________** Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: Colonoscopy, sigmidodoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP), Pneumatic or mechanical esophageal dilation (not with bougie or olive), Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists who have completed a cardiovascular subspecialty training), Any laser procedure, Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue, Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae **No procedures performed on a patient while under general anesthesia.**
☐	**Major Surgery**	**# Annually:____________** Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length or circumstances of an operation or procedure. It includes discograms, lymphangiography, myleography, phlebography, pneumoencephalography and radiation therapy. It also includes removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.
☐	**Perform Obstetrical Procedures**	**# Annually:_____________** Prenatal care and/or Deliveries
☐	**Assisting in surgery on your own patients**	**# Annually:_____________**
☐	**Assisting in surgery on patients other than your own**	**# Annually:_____________**

d. Do you provide care for minors? If yes, % of practice:________________ ☐ Yes ☐ No

e. Do you perform any procedures which require specialized training (e.g. bariatrics)? ☐ Yes ☐ No
If yes, please list these procedures in the Comments Section.

f. Do you perform medical legal evaluations? If yes, for whom?_________________________ ☐ Yes ☐ No
What % of your practice:___________

g. Will you be performing activities that will be covered by another professional Liability policy? ☐ Yes ☐ No
If yes, please provide complete details (include name and address of entity) in the comments Section and provide proof of coverage.

h. Do you work in an Emergency Room? ☐ Yes ☐ No
If yes, is this solely to satisfy requirements for hospital privileges? ☐ Yes ☐ No

i. Are you a sports team physician or health care provider? ☐ Yes ☐ No

j. Do you perform any surgery in your office? ☐ Yes ☐ No
If yes, describe and include type of anesthesia (local, sedation, general):___________________________________
____

k. Do you perform surgery in other non-hospital facilities? ☐ Yes ☐ No
If yes, name the facilities and type of surgical procedures performed._____________________________________
____

l. In the course of surgery described above, is general anesthesia administered? by you? ☐ Yes ☐ No
by others? ☐ Yes ☐ No

m. Do you personally provide pre-operative exams and post-operative care for all surgical patients? ☐ Yes ☐ No

n. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center? . ☐ Yes ☐ No
If yes, please provide details in Comment Section

9. AFFILIATIONS

a. Do you hold any positions as director or trustee of any licensed hospital or medical institution? ☐ Yes ☐ No
If yes, please provide complete details on Comments Section.

b. Do you have any teaching responsibilities? ☐ Yes ☐ No
If yes, identify name and location of institution:____
Does this institution provide you insurance coverage for your supervision of residents? ☐ Yes ☐ No
What percentage of your weekly time is spent supervising residents?__________%
If no insurance has been provided by this institution for your services, please attach a copy of your contract or letter of agreement for our review.

c. Do you have any medical director responsibilities? ☐ Yes ☐ No
If yes, identify name and location of entity:____
Does the entity provide you with insurance for your administrative responsibilities? ☐ Yes ☐ No

Does the entity provide you with insurance for your direct patient care? ☐ Yes ☐ No
If insurance is not fully provided by the entity, please attach a copy of your contract or letter of agreement.

d. Do you participate in quality assurance, peer or utilization review activities for others? □ Yes □ No

e. Do you have management responsibilities at a facility or organization not owned by you? □ Yes □ No
If yes, is your malpractice insurance coverage provided by the entity? □ Yes □ No
If yes, please provide complete details in the Comments Section, including name and location of entity, your title, and responsibilities and duties.
If insurance is not fully provided by the entity, please attach a copy of your contract or letter of agreement.

f. Do you treat patients at a Long Term Care facility? □ Yes □ No
Nursing Home If yes, % of your practice:__________
Skilled Nursing Facility If yes, % of your practice:__________
Assisted Living Center If yes, % of your practice:__________

g. Do you provide services as a locum tenens? □ Yes □ No
If yes, answer the following:
Name of each company that places you in locum positions:____
Are you an □ employee or □ independent contractor?
Number of hours each month in which you work in locum positions:____________
Is your malpractice insurance coverage provided for locum positions? □ Yes □ No

h. Do you provide services to any adult or juvenile inmates in any local, state, or federal correctional facility, jail, prison, holding facility and/or any other institution? □ Yes □ No
If yes, please provide complete details in the Comments Section.

i. Are you engaged in or planning to engage in any "moonlighting" activities? □ Yes □ No
If yes, do you want coverage for your "moonlighting" activities?
If yes, describe the activities.____

j. Do you provide medical professional services (including opinions or advice) via the internet or any telemedicine programs? □ Yes □ No
If yes, % or your practice:_________
If yes, do you refer patient to see local primary care physician?

k. Do you prescribe drugs via the Internet? □ Yes □ No
If yes, provide details on Comment Sheet.

l. Do you or your employees provide home health or mobile health care services? □ Yes □ No

m. Have you participated in any fashion whatsoever in a clinical trial within the last ten years? □ Yes □ No

n. Are you now or have you ever performed experimental or investigational procedures or prescribed/ dispensed experimental drugs? □ Yes □ No
If yes, please provide details in Comments Section

o. Do you practice in any other capacity not already identified thus far in this application? □ Yes □ No
If yes, please provide complete details in Comments Section.

10. PROCEDURES

Please review carefully and check all items that apply to your practice, even if the procedures are outside your specialty. *For any items marked with an asterisk, please provide evidence of training.

□ **Alternative Medicine** - Describe procedures and annual number performed in Comments Section

□ Acupuncture □ Acupressure □ Chelation Therapy □ Chinese Medicine
□ Holistic Medicine □ Homeopathic Medicine □ Marijuana treatments and/or prescriptions
□ Naturopathic Medicine □ Other:______________________________

□ **Anesthesia** (check type and where administered)

	Hospital	Surgical Suite	Office
□ Caudal	□	□	□
□ Moderate (Conscious) Sedation	□	□	□
□ General	□	□	□
□ Spinal	□	□	□

□ Lumbar Puncture – Number per year:____________

□ **Pain Management**

□ Medication Only □ Blocks □ Epidurals □ Trigger Point Injections
□ Surgically Implanted Devices Performed on neck and spine □ Yes □ No

□ Do you prescribe synthetic opiates? □ Yes □ No
□ In the comments section or on a separate sheet, describe your controls in place to reduce or eliminate drug seeking behavior.

Complete the Anesthesia Supplemental Application

□ **Bariatrics/Weight Control**

□ Diet, Exercise, and Vitamins only
□ Drugs and/or Injections – List all medications/injections prescribed and describe protocols in the Comments Section
□ Surgery
□ Roux-en-Y – Annual Number:____________ □ Banding – Annual Number:__________
□ Gastric By-Pass/Stapling/Restriction and/or Other Procedures – Annual Number:____________

Complete the Bariatric Supplemental Application

□ **Cosmetic/Dermatological Procedures**

□ Blepharoplasty □ Botox Injections □ Chemical Peels □ Collagen and/or Other Injections
□ Cryosurgery (superficial) □ Chemabrasion □ Dermabrasion □ Dermatopathology (diagnostic)
□ Fat Transfer □ Hair Growth/Transplants □ Laser Hair Removal* □ Laser Procedures – Other*
□ Lipodissolve/ Mesotherapy
□ Liposuction (under 3500 CC's Volume) □ Liposuction (3500 cc's or more volume)
□ Microdermabrasion □ Sclerotherapy □ Silicone Injections □ Other Injections:____________
□ Other:______________________________

□ Cosmetic Plastic Surgery - Elective % of Elective:_______________
□ Cosmetic Plastic Surgery - Reconstructive % of Reconstructive:__________

Describe procedures and annual number performed in Comments Section

****For any items marked with an asterisk, please provide evidence of training.***

□ **Gynecology/Obstetrics**

□ Office Gynecology Only
□ Pre-natal care through 1st trimester only
□ Pre-natal care through 2nd trimester only
□ Pre-natal care full term
□ Amniocentesis
□ High Risk Pregnancies
□ Toxemia Management
□ Dilation and Curettage
□ Cryosurgery
□ Norplant Insertion
□ Fertility/Infertility Treatment

□ Elective Abortions
Number each month:________________
Maximum Gestation Age:____________
Where performed:__________________
□ Therapeutic Abortions
Number each month:________________
Maximum Gestation Age:____________
Where performed:__________________

□ Hormone Replacement Therapy, HGH, and/or HCG
□ Insertion of intrauterine or subcutaneous contraceptive devices

□ **Obstetrics - Complete the Obstetrics Supplemental Application**

Indicate annual number of:
□ Vaginal Deliveries:__________
□ VBAC Deliveries
□ Cesarean Sections:____________
□ Non-Hospital Deliveries:_______

Indicate the percentage of:
□ Low Forceps deliveries:_______% □ Mid Forceps Deliveries:______% □ Breech Deliveries:______%

Do you personally attend each delivery? □ Yes □ No
Does a Midwife perform any actual deliveries/births? □ Yes □ No
If yes, annual number performed by Midwife:__________________

□ **Podiatry** Check the procedures that you perform:

□ Reduction of simple fractures of the heel or ankle
□ Reduction of compound fractures of the heel or ankle
□ Use of Lasers
□ Arthrodesis
□ Cutting or penetration of tissue other than that as defined as "No Surgery" above on page 7
□ Permanent removal of nail plate except by the use of electrical or chemical cautery
□ Surgical procedures of the ankle joint which includes any of the following:
- Tibia and/or fibula and their related structures - Arthroplasty - Grafts and/or implants
□ Surgical treatment of the muscles and tendons at the level of the ankle joint
□ Any other surgical procedures performed on the foot and/or ankle
Please describe:____

□ **Radiology** □ **Diagnostic** □ **Interventional**

□ Fluoroscopy □ Mammography □ Myelography □ Radiation/X-Ray Therapy □ Nuclear Medicine
□ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae

Annual number of readings performed:________
Type of readings performed:____

Do you read, interpret, and/or diagnose files, electronic images, or slides of patients residing in any state(s) other than your primary practice state address? □ Yes □No
If yes, specify on Comments section or additional page the state(s) and percentage of your total practice.

□ **Surgical (Invasive) Procedures   Check all items that apply to your practice**

□ Angioplasty	□ Hysterectomy
□ Appendectomies	□ Hysteroscopy
□ Assist in Surgery	□ Neurological Surgery
□ Bariatric Surgery	□ Obstetrics/Gynecology – Major Surgery
□ Bronchoscopy	□ Ophthalmology Surgery
□ Cardiac Surgery	□ Orthopedic – Major Surgery □ Spine □ No Spine
□ Cataract Surgery	□ Otorhinolaryngology – Major Surgery
□ Cholecystectomy	□ Including Elective Cosmetic Procedures
□ Circumcision (other than newborns)	□ Penile Implants
□ Colonscoopy	□ Pacemaker – Permanent or Temporary
□ Cryosurgery (other than external lesions)	□ Plastic – Major Surgery
□ Dilation and Curettage	□ Robotic Surgery *(*Evidence of training required)*
□ Endoscopic Laser Therapy	□ Thoracic Surgery: _______% of Practice
□ Endoscopy	□ Tonsillectomy/Adenoidectomy
□ ERCP/EGD/ERC	□ Transgender Surgery
□ Fracture Reductions □ Open □ Closed	□ Transplant Surgery
□ Hand Surgery	□ Tubal Ligation
□ Head and Neck Surgery	□ Trauma Surgery
□ Heart Catheterization	□ Urological Surgery
□ Hemorrhoidectomy	□ Vascular Surgery: _______% of Practice
□ Hernia Repair	□ Vasectomy

□ **Other   Check all items that apply to your practice**

□ Angioplasty, Arteriography	□ Breast Biopsy	□ Chelation Therapy
□ Detoxification	□ Disability Evaluation	□ ECT Electric Shock Therapy
□ Electro Convulsive Therapy	□ Emergency Medicine	□ Esophageal Gastro Dilation
□ Experimental procedures	□ Fertility Treatment	□ Hormone Replacement Therapy
□ Hyperbaric Chamber treatment	□ Hyperbaric Medicine/Wound Care	□ Hypnosis
□ Independent Medical Exams: _______% of Practice	□ Manipulation Under Anesthesia	□ Marijuana Treatments and/or Prescriptions
□ MOHS microscopic surgery	□ Needle biopsy	□ Neonatology
□ Radial Keratotomy LASIX, PRK, AKL, OR PTK	□ Radiation Oncology	□ Shock therapy (E.C.T.)
□ Telemedicine	□ Urgent Care	□ Urological non-surgical treatments
□ Vein treatments		

Any procedures not customary to your specialty:____

11. PROFESSIONAL INFORMATION

If you answer yes to any of the following questions, please provide details on the Comments Page.

a. Have you ever had membership in any professional association or society refused, suspended or revoked? □ Yes □ No

b. Have you ever been investigated, disciplined, censured, or reprimanded by a professional society or a licensing board? □ Yes □ No

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

d. Are there any restrictions on your current hospital privileges? □ Yes □ No

e. Has any hospital or other institution ever reprimanded you, restricted, reduced, refused, or suspended your privileges and/or invoked probation? □ Yes □ No

f. Have you ever been under any hospital disciplinary observation, preceptorship, or sponsorship? □ Yes □ No

g. Have you ever voluntarily surrendered or had you license to prescribe and/or dispense narcotics refused, suspended, limited in any way, or revoked? □ Yes □ No

h. Have you ever voluntarily surrendered or had any state license to practice medicine refused, restricted, suspended, revoked, or are you now on probationary status? □ Yes □ No

i. Have you ever been treated for alcoholism, mental illness, or narcotics addiction? □ Yes □ No

j. Have you ever been accused of sexual misconduct of any kind? □ Yes □ No

k. Have you ever used any intoxicant, narcotic, marijuana or other psycho-active drug to the extent that it either has interfered with your ability to perform professional services or caused you to seek medical advice or treatment? □ Yes □ No

l. Do you currently have any health problem, illness, or physical condition that impairs or could impair your ability to practice medicine? □ Yes □ No

m. Has any physician, professional, patient, patient family member, or employee ever filed a complaint against you with any professional society, licensing board, board of examiners, or similar organization? □ Yes □ No

12. INSURANCE HISTORY AND LOSS INFORMATION

a. List your prior Professional Liability Insurance for each of the last ten (10) years, beginning with your current Insurer.

Policy Period	Insurance Carrier	Policy Limits	Claims-Made-CM Occurrence -Occ	Premium	*Total # of Claims
			□ CM □ Occ		
			□ CM □ Occ		
			□ CM □ Occ		
			□ CM □ Occ		
			□ CM □ Occ		
			□ CM □ Occ		
			□ CM □ Occ		

***Total # of claims, by carrier, regardless of payment, no-payment, dismissal or status**.

b. Have you ever practiced without professional liability insurance? □ Yes □ No
If yes, specify dates: from_________________until_____________________

c. Have you ever had any professional liability insurance refused, canceled, rescinded or non-renewed? □ Yes □ No
(Response not required in the State of Missouri)

d. Have you ever been notified of your involvement in a malpractice claim, suit, or incident, either directly or indirectly? □ Yes □ No
If yes, please complete Form A attached for each claim, suit, incident and submit the completed Form A with this supplemental application.
If yes, were each of those claims, suits, or incidents reported to your malpractice insurer(s)? □ Yes □ No

e. Are there any claims or suits threatened or pending against you 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 your current or prior insurers? □ Yes □ No

f. Has any incident, claim, and/or suit involving you been reported to another insurer by any of your current or former employees, partners, or associates on their own behalf, but not reported on your behalf? □ Yes □ No

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

13. PRIOR ACTS COVERAGE

NOTE: If you wish to obtain coverage for Professional Medical Services that took place prior to your Requested Effective Date shown under section 3, you must indicate the date that you wish coverage to begin. This date is the Requested Retroactive Date. The period between the Requested Retroactive Date and the Requested Effective Date defines the Prior Acts period.

You are not eligible for Prior Acts Coverage unless you maintained continuous claims-made professional liability insurance with your own limits of liability during the entire requested Prior Acts Coverage period. Please provide a copy of your expiring professional liability policy declarations and all endorsements.

Did you practice with other physicians in an employer-employee relationship, locum tenens, ostensible or formal partnership, medical association or medical corporation during the period for which you are requesting Prior Acts Coverage? □ Yes □ No
If yes, complete the information below. Use the Comments Section or attach additional pages as needed.

Name of Entity	Name of Physician	Dates From/To

NON-PHYSICIAN HEALTH CARE PROVIDERS
Did you employ, contract with or supervise any non-physician health care providers, (i.e. physician's assistants, nurse practitioners, LPN's, RN's, etc.) during the period for which you are requesting Prior Acts Coverage? Provide details in the Comments Section. □ Yes □ No

CHANGES IN PRACTICE
Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in this application for Medical Professional Liability Claims-Made coverage. □ Yes □ No

For instance, did your practice formerly include obstetrical care or emergency room services that you are no longer providing, or did you ever perform cosmetic procedures of any kind? □ Yes □ No
Did any of your policies contain any coverage restrictions? □ Yes □ No

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 c-e of the application.

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
    □ Suit filed but dropped by claimant
    □ Summary judgment in your favor
    □ Settled out of Court
    Date Claim paid:________________
    Amount paid on your behalf: $__________________
    □ Court outcome in your favor
    □ jury verdict
    □ directed verdict
    □ Court outcome in favor of plaintiff
    □ jury verdict
    □ directed verdict
    verdict amount:$_____________
    □ Open – Status Pending
    □ Awaiting mediation/arbitration
    □ Awaiting Court action
    Reserve 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 Company may disclaim coverage on a liability insurance policy on the ground that the insured or a person claiming the benefits of the policy through the insured has breached the policy by failing to cooperate with the Company or by not giving the Company required notice only if the Company establishes by a preponderance of the evidence that the lack of cooperation or notice has resulted in actual prejudice to the insurer. Under such circumstances the Company will not pay damages or claim expenses nor provide a defense to such claim.

In addition, such misstatements or failure to cooperate may result in cancellation of the policy or recalculate the premium during the underwriting period. The insurance policy is subject to a 45 day underwriting period beginning on the effective date of coverage, and notice of cancellation or recalculated premium is sent to the insured 15 days prior to cancellation.

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.

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

FRAUD DISCLOSURE STATEMENT

"Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

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.