231 S. Bemiston Ave., Suite 1000
St. Louis, MO 63105
Telephone: (314) 721-2366
Facsimile: (314) 721-2377

GROUP OR ENTITYAPPLICATION FOR PROFESSIONAL LIABILITY POLICY

CLAIMS MADE 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", "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.

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.

If additional forms are required or if a question arises about the application process, please call the Company at: 314-721-2366.

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.

Galen Insurance Company
231 S. Bemiston Ave., Suite 1000
St. Louis, MO 63105
Telephone: (314) 721-2366
Fax: (314) 721-2377

GROUP/ENTITY
PROFESSIONAL LIABILITY
INSURANCE APPLICATION

Please answer all questions fully and completely. If you do not have enough space to provide a complete answer, use Part VII, the Comments Section, of this application, or attach separate pages, identifying the question and providing the additional information necessary for a complete answer. PLEASE TYPE OR PRINT LEGIBLY.

PART I: APPLICANT INFORMATION

1. Name:_____

2. Street Address:_____

3. City, State, Zip Code, County:_____

4. P.O. Box Address:_____

5. Billing Address:_____

6. Office Telephone:_____ 7. Office Facsimile:_____

8. E-Mail Address:_____ 9. Website Address:_____

10. Date Established:_____ 11. Number of Employees:_____

12. Federal Tax Id. #:_____ 13. Total Annual Gross Receipts:_____

14. Type of Practice:_____ 15. Contact Person:_____

16. Requested Effective Date:_____ 17. Requested Retroactive Date:_____

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

Individual	☐	Joint Venture	☐	For Profit	☐	Other (describe) _____
Corporation	☐	Governmental	☐	L.L.C.	☐	_____
Partnership	☐	Not-For-Profit	☐	Charitable	☐	_____

19. 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.

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

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

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

23. 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?_____

24. Identify the geographical area in which Applicant operates:_____

24. 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.

25. 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 II – LIMITS AND DEDUCTIBLES REQUESTED

1. Separate limits requested for: Named Insured(s):_____
☐ $1,000,000 Per Claim, $3,000,000 Annual Aggregate
☐ Other: $_____ Per Claim, $_____ Annual Aggregate

2. Shared limits requested for: Named Insured(s):_____
☐ $1,000,000 Per Claim, $3,000,000 Annual Aggregate
☐ Other: $_____ Per Claim, $_____ Annual Aggregate

3. Deductible requested:
☐ Zero ☐ $5,000
☐ $1,000 ☐ $10,000
☐ $2,500 ☐ 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. In Part VII of this application, please identify the number and specialty of each physician and allied professional employed by or contracted with the Applicant. Please identify below the total number of physicians and allied professionals employed by or contracted with the Applicant.

	Employees:	Independent Contractors:
Physicians	_____	_____
Allied Professionals	_____	_____
Others	_____	_____

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.

Name of Physician:	From Mo/Yr - To Mo/Yr:	Tail Coverage Purchased:
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ 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.

Name of Allied Professional:	From Mo/Yr - To Mo/Yr:	Tail Coverage Purchased:
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ No
____________	____________	☐ Yes-unlimited ☐ Yes-limited ☐ 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 VII 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. Does the Applicant do business outside the State of Missouri? ☐ Yes ☐ No
   If yes, please provide information in Part VII of this application or on a separate sheet regarding the Applicant's or applicable individual(s) name(s), state, dates, and the percentage of practice for the past ten years.

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 – INFORMATION REQUIRED

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

- ☐ Organizational charts (including affiliates, governing body, officers, departments and management).
- ☐ 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.
- ☐ List all physicians and other allied professionals who are associated with the practice, but not employed or contracted with the practice and for whom coverage is not being sought. Indicate their association (e.g., share office or professional employees, such as a nurse or technician; common letterhead; see each other's patients on a regular basis; share calls; common billing statements (as opposed to utilizing the same billing service); all providers' names appear together on the office door; or share overhead expenses).
- ☐ Facility's risk management plan.
- ☐ 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 managed care agreements and other agreements under which professional services are provided.
- ☐ All agreements where other parties are indemnified.
- ☐ All prior professional liability policies, including declaration pages and endorsements.
- ☐ Licenses and certificates for all physicians, nurse practitioners, nurse anesthetists, midwives, optometrists, and physician assistants for whom coverage is sought.
- ☐ All physician supervisory certificates or agreements for nurse practitioners, nurse anesthetists, midwives, and physician assistants for whom coverage is sought.
- ☐ Authorizations for release of information (see form attached) signed by the Facility on behalf of all affiliates, and facilities for whom coverage is sought.
- ☐ Applicant's letterhead and all advertisements in the past two years.

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

Page Number	Question Number	Comment

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 No: _____

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.

Print Applicant (Proposed Policyholder) Name:_____

Signature _____ Date _____

Print Signer's Name and Title:_____