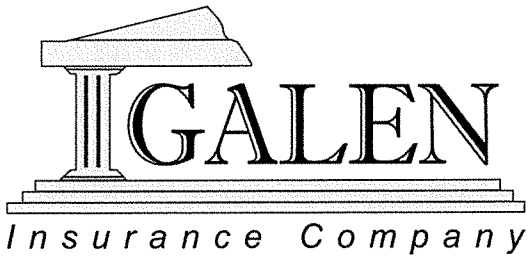

231 South Bemiston, Suite 1000
St. Louis, MO 63105
Telephone: (314) 721-2366
Facsimile: (314) 721-2377

PHYSICIAN'S APPLICATION 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", or "we" or "us") to issue insurance.

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 Comments Section, 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 additional information (and related checklist) required and outlined at the end 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, 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 South Bemiston, Suite 1000
St. Louis, MO 63105
Telephone: (314) 721-2366
Facsimile: (314) 721-2377

PHYSICIAN APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

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

Personal Information

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

2. Date of Birth:_____ 3. SS#_____ 4. ☐ Male ☐ Female

5. Home Address: _____ 6. Home Phone: _____

7. Email address: _____ 8. M.D. or D.O or other_____

9. Are you a U.S. Citizen? ☐ Yes ☐ No; If no, please describe your current status, including your intentions regarding future citizenship:_____

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

10. Have you ever had your membership in any professional society or association refused, suspended, revoked or ever received any criticism or reprimand from any professional society? ☐ Yes ☐ No

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

12. Are there any restrictions on your current hospital privileges? ☐ Yes ☐ No

13. Has any hospital or other institution ever restricted, reduced, refused, or suspended your privileges or invoked probation? ☐ Yes ☐ No

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

15. Have you ever voluntarily surrendered or had your license to prescribe or dispense narcotics refused, suspended, limited in any way, or revoked? ☐ Yes ☐ No

16. Are you now on probationary status? ☐ Yes ☐ No

17. 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

18. Have you ever voluntarily surrendered or had any state license to practice medicine refused, restricted, suspended, or revoked? ☐ Yes ☐ No

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

20. Have you ever used any intoxicant, narcotic, 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

21. Do you currently have any health problem, illness, or physical condition that impairs or could impair your ability to practice medicine? ☐ Yes ☐ No
If yes, please submit a letter from your treating physician addressing your state of health and whether any conditions exist that could adversely affect the practice of medicine by you.

22. Has any physician, professional, or patient ever filed a complaint against you with any professional society, licensing board, board of examiners, or similar organization? ☐ Yes ☐ No
If yes, please provide copies of complaint and disposition documents.

Policy Information:

23. What would the effective date of your policy be? _____

24. If seeking prior acts coverage, what would your retroactive date be? _____

25. Will you be the policyholder, or a named insured on a group policy? ____ Policyholder
____ Named Insured/Member of Group

If a named insured/member of a group, what is the group name? _____

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

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

28. Deductible requested:
☐ Zero ☐ $5,000
☐ $1,000 ☐ $10,000
☐ $2,500 ☐ Other: $_____

Educational Information and Licenses/Certification

29. Medical School: _____ Dates: From _____ To _____
City: _____ State: _____ Country: _____ Degree: _____

30. Internship - Facility Name: _____ Dates: From _____ To _____
City: _____ State: _____ Country: _____ Specialty: _____

31. Residency - Facility Name: _____ Dates: From _____ To _____
City: _____ State: _____ Country: _____ Specialty: _____
Type of Residency: _____ Completed: ☐ Yes ☐ No

32. Other Training (fellowships, military service, etc.):
Name, location, and type: _____ Dates: From _____ To _____
Name, location, and type: _____ Dates: From _____ To _____

33. If you are a foreign medical school graduate, are you certified by the Education Commission for Foreign Medical School Graduates (ECFMG)? ☐ Yes ☐ No
If licensed by ECFMG, identify states or countries, license number, and date: _____

34. Do you hold the foreign equivalent of board certificates? ☐ Yes ☐ No
If no, please explain _____

35. List the states in which you are currently licensed:
State:_____ License No.:_____ Active? ☐ Yes ☐ No
State:_____ License No.:_____ Active? ☐ Yes ☐ No

36. DEA License Number: _____ Dates: From _____ To _____

37. Identify all medical and professional societies to which you belong:_____
_____

38. Do you have board certification recognized by the American Board of Medical Specialists or the American Osteopathic Association?..... ☐ Yes ☐ No
If yes, identify: Specialty_____ Subspecialty_____

If not board certified, why:
_____

Please identify the date you plan to become board certified:_____

39. Have you ever been refused board certification?..... ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this application.

40. What percentage of your practice is devoted to your specialty and subspecialty?
Specialty: _____% Subspecialty: _____%

Practice Information

41. Practice Name: _____

42. Practice Address: _____

43. Practice Phone, Fax and Contact Person: P:_____ F:_____ Contact:_____

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

45, If you perform surgery, please list the five procedures you perform most often, the approximate % of your practice these procedures represent and how long you have performed these procedures:

Procedure	%	Years

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

47. Do you provide care for minors?..... ☐ Yes ☐ No
If yes, how much of your practice consists of the treatment of minors?_____

48. Do you practice in states other than Missouri? ☐ Yes ☐ No
If yes, please list states and the percentage of your time practicing there:

State	County	% of practice
_____	_____	_____
_____	_____	_____

49. Are you entering private practice for the first time? ☐ Yes ☐ No

50. List all locations (names and addresses) where you have practiced since residency
Present location:_____ Dates: From _____ To _____
Prior location:_____ Dates: From _____ To _____
Prior location:_____ Dates: From _____ To _____

51. Please explain any gaps in your training or practice, if not explained in your curriculum vitae:_____
_____

52. How many category 1 credit hours of continuing medical education do you attend annually? _____

53. Do you hold any positions as director or trustee of any licensed hospital or medical institution? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this application.

54. Do you perform any medical legal evaluations? ☐ Yes ☐ No
If yes, for whom?_____
What percentage of your practice does this entail? _____%

55. Do you have any teaching responsibilities? ☐ Yes ☐ No
If yes, identity 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.

56. 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.

57. Do you employ or supervise any physicians or allied professionals? ☐ Yes ☐ No
If yes, specify the number, role and type of physician or allied professional.

Number:	Employ or Supervise:	Type:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

58. 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 Part VII of this application and provide proof of coverage.

59. Do you treat prison or jail inmates? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this application.

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

61. Do you have management responsibilities at a facility or organization not owned by you? ☐ Yes ☐ No

62. If yes to Question 61, is your malpractice insurance coverage provided by the entity? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this application, including the 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.

63. Have your practice specialties or procedures changed in the past five (5) years? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this application of how the specialties or procedures have changed and give the dates of changes.

64. 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

65. 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

66. Do you practice in any other capacity not already identified thus far in this application? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this application.

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

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

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

70. Do you personally provide pre-operative exams and post-operative care for all surgical patients? ☐ Yes ☐ No
If no, please explain: _____

71. PLEASE REVIEW CAREFULLY AND CHECK AND COMPLETE ALL ITEMS THAT APPLY TO YOUR PRACTICE, EVEN IF THE PROCEDURES ARE OUTSIDE YOUR SPECIALTY OR DUPLICATIVE. For any item marked with an asterisk, please provide proof of training and certificates of completion.

- ☐ Abdominoplasty
- ☐ Abortions – First Trimester; # Per Year:_____
- ☐ Abortions – Therapeutic
- ☐ Acupuncture, anesthesia
- ☐ Acupuncture, therapy
- ☐ Acupuncture, other
- ☐ Amniocentesis
- ☐ Anesthesia – surgical
- ☐ Anesthesia – caudal
- ☐ Anesthesia – epidural
- ☐ Anesthesia - general
- ☐ Anesthesia – Local
- ☐ Angiography – lymph
- ☐ Angiography, other _____
- ☐ Angioplasty
- ☐ Appendectomy: # Per Year:_____
- ☐ Arteriography
- ☐ Assisting in Surgery – own patients
- ☐ Assisting in Surgery – Patients of Others
- ☐ Autologous Fat Injection – Breast
- ☐ Autologous Fat Injection – Penis
- ☐ Bartholin cyst or abscess, I&D
- ☐ Biopsy, Breast, cyst aspiration
- ☐ Biopsy, Breast, excisional
- ☐ Biopsy, Breast, incisional
- ☐ Biopsy, Breast needle
- ☐ Biopsy , Cervical
- ☐ Biopsy, Heart
- ☐ Biopsy, Liver
- ☐ Biopsy, Skin
- ☐ Biopsy, Other _____
- ☐ Blepharoplasty – Cosmetic
- ☐ Blepharoplasty - Functional

- ☐ Blocks - Caudal Epidural
- ☐ Blocks - Celiac Plexus
- ☐ Blocks - Cervical
- ☐ Blocks - Cervical Epidural
- ☐ Blocks - Differential Spinal
- ☐ Blocks - Facet Injection, Lumbar only, under Fluoroscopy
- ☐ Blocks - Facet Injection, other than Lumbar, under Fluoroscopy
- ☐ Blocks - Facet Joint Block
- ☐ Blocks - Lumbar
- ☐ Blocks - Lumbar Epidural
- ☐ Blocks - Lumbar Sympathetic
- ☐ Blocks - Motor Point and Peripheral Nerve
- ☐ Blocks - Peripheral Nerve
- ☐ Blocks - Retrobulbar
- ☐ Blocks – Spine*
- ☐ Blocks - Spinal Nerve
- ☐ Blocks – Non-spine*
- ☐ Blocks - Stellate Ganglion
- ☐ Blocks - Subarachnoid Block
- ☐ Blocks - Supraclavicular
- ☐ Blocks - Suprascapular Nerve
- ☐ Blocks - Sympathetic Nerve
- ☐ Blocks - Thoracic
- ☐ Blocks - Trigger Point Pain Injection
- ☐ Bone Marrow Aspiration
- ☐ Bone marrow biopsy
- ☐ Botox Injections - Cosmetic*
- ☐ Botox Injections – Pain Management*
- ☐ Botox Injections – Other*
- ☐ Breast Augmentation or Reduction
- ☐ Browplasty/Brow Lift
- ☐ Buccal Fat Extraction
- ☐ Cardiac Bypass Pump
- ☐ Cardiac Catheterization, Left Heart
- ☐ Cardiac Catheterization – Right Heart (Swan Ganz)
- ☐ Cataract Surgery, lens implant
- ☐ Cataract Surgery, no lens implant
- ☐ Cesearean section
- ☐ Cervical Discograms
- ☐ Cervical Disc Nucleoplasty
- ☐ Chalazion Excision from Eyelids
- ☐ Chelation Therapy
- ☐ Chemical Peel
- ☐ Chemical face peel with phenol*
- ☐ Chemotherapy
- ☐ Circumcisions – Adult
- ☐ Circumcisions – Pediatric
- ☐ Closed reductions of simple fractures; # Per Year:_____
- ☐ Closed reductions - other; # Per Year:_____
- ☐ Collagen Injection
- ☐ Colposcopy
- ☐ Cone biopsy
- ☐ Cordotomies
- ☐ Corneal Transplant
- ☐ Cosmetic, Other - Identify all procedures not listed on separate sheet
- ☐ Cosmetic, Ear Surgery
- ☐ Cosmetic, Major Surgery
- ☐ Cryanalgesia
- ☐ Cryosurgery, benign or pre-malignant dermatological lesions
- ☐ Cryotherapy
- ☐ Cystoscopy
- ☐ Dermabrasion/ Chemabrasion
- ☐ Dermatology
- ☐ Dermatology: Acne surgery
- ☐ Dermatology: Collagen injection
- ☐ Dermatology: Liposuction
- ☐ Dermatology: MOHS surgery
- ☐ Dilation and Curettage # Per Year:_____
- ☐ Digital Subtraction Angiography
- ☐ Discograms
- ☐ Dorsal Column Stimulator Implant or Reprogram
- ☐ Electric Shock Therapy
- ☐ Electrosurgical Procedures
- ☐ Endometrial Aspiration
- ☐ Endometrial Biopsy
- ☐ Endoscopy – Bronchoscopy
- ☐ Endoscopy, Colonoscopy
- ☐ Endoscopy, Esphagoscopy
- ☐ Endoscopy, Gastroscopy
- ☐ Endoscopy, Pelvioscopy
- ☐ Endoscopy, Protoscopy
- ☐ Endoscopy, Sigmoidoscopy, flexible to 65cm
- ☐ Endoscopy, Signoidoscopy, flexible to above 65cm
- ☐ Ensocsopy, Sigmoidoscopy, rigid
- ☐ Endoscopy, ERCP
- ☐ Endoscopy, Other: _____
- ☐ Enucleation
- ☐ Epidural or Spinal Catheters
- ☐ Epikeratophakia (KME)
- ☐ EPS (provocable electrophysiologic tests)
- ☐ Excisions, Simple
- ☐ Excisions of skin lesion(s) with graft or flap repair
- ☐ Fertility Counseling/Artificial Insemination
- ☐ Fibrel Injection
- ☐ Face Lifts
- ☐ Fat Transplantation
- ☐ FDA Approved Experiments
- ☐ Fracture Reduction – Closed – Simple
- ☐ Fracture Reduction – Closed – Other than Simple
- ☐ Fracture Reduction – Open
- ☐ Fluroscopy
- ☐ Gastric Balloon
- ☐ Hair Transplant - Human Hair
- ☐ Hair Transplant - Synthetic Hair Fibers
- ☐ Hand Surgery
- ☐ Hemorrhoidectomies; # Per Year:_____
- ☐ Hemorrhoidectomy – Ligation Only
- ☐ Hemorrhoidectomy – Other than Ligation
- ☐ Histories and Physicals
- ☐ Home Services
- ☐ Human Growth Hormone
- ☐ Hypnosis
- ☐ Hysterectomy – Abdominal
- ☐ Hysterectomy - Other
- ☐ In Vitro Fertilization (IVF)
- ☐ Independent Medical Evaluations
- ☐ Injections for chymopapain or those containing sclerosing agents
- ☐ Intraop EEG/EP Monitor
- ☐ Intravascular absolute alcohol embolization
- ☐ Intra-Articular Block (Joint Injections)
- ☐ Intradiscal Electrothermal Therapy
- ☐ Intravenous Regional Anesthesia
- ☐ IUD Insertion or Diaphragm Fitting
- ☐ Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity
- ☐ Joint Injection (Intra-articular Block)
- ☐ Keratotomy
- ☐ Laceration Repairs
- ☐ Laparoscopy
- ☐ Laser Hair Removal
- ☐ Laser Skin Resurfacing – Face Only
- ☐ Laser Skin Resurfacing – Other
- ☐ Laser Surgery
- ☐ LASIK*
- ☐ Leeps/Leetz Procedure
- ☐ Lens implant, no cataract surgery
- ☐ Lid Repair
- ☐ Lumbar Discograms
- ☐ Lumbar Disc Nucleoplasty
- ☐ Lumpectomy-Superficial Skin Lesion
- ☐ Lumpectomy – Other
- ☐ Mammoplasty
- ☐ Management of Ectopic Pregnancy
- ☐ Manipulation or Massage
- ☐ Manipulation Under Anesthesia
- ☐ Mastectomy
- ☐ Mesotherapy
- ☐ Myelography
- ☐ Myofascial Trigger Point Injections
- ☐ Myringotomy
- ☐ Needle Biopsy – including lung and prostrate
- ☐ Needle Biopsy – including liver, kidney, or bone marrow biopsy
- ☐ Nerve Root Injections
- ☐ Non-FDA Approved Experiments or Studies
- ☐ Nuclear Medicine
- ☐ Obstetrical Deliveries – Birthing Center; # per YR:_____
- ☐ Obstetrical Deliveries – Birthing Center; # per YR:_____
- ☐ Obstetrical Deliveries – Home or Other; # per YR:_____
- ☐ Office Gynecology
- ☐ Ophthalmic plastic surgery, cosmetic
- ☐ Orthopedic: Non-surgical care ONLY
- ☐ Otoplasty
- ☐ Pacemaker implant-temporary
- ☐ Pacemaker implant, permanent
- ☐ Pain Control or Management – Medication Only
- ☐ Pap Smears
- ☐ Paraentisis
- ☐ Pars plana vitrectomy
- ☐ Pelvic Examination
- ☐ Percutaneous Discectomy
- ☐ Percutaneous Transluminal Coronary Angioplasty
- ☐ Percutaneous Valvuloplasty
- ☐ Peripheral Nerve Stimulation
- ☐ Photorefractive Keratotomy (PRK)
- ☐ Phototherapeutic Keratotomy (PTK)
- ☐ Physical Therapy

- ☐ Prenatal Exam – Diagnose Only (refer to others)
- ☐ Prenatal Exam – 1st Trimester
- ☐ Prenatal Exam – 2nd Trimester
- ☐ Prenatal Exam – 3rd Trimester
- ☐ Pneumoencephalography
- ☐ Prolotherapy
- ☐ Prolotherapy with Phenol
- ☐ Prolothearpy without Phenol
- ☐ Radio Frequency Nerve Ablation
- ☐ Radial Keratotomy
- ☐ Radiation Therapy
- ☐ Radioplaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae
- ☐ Rapid Detoxification
- ☐ Refractive keratoplasty, other
- ☐ Removal of moles and warts
- ☐ Renal Dialysis
- ☐ Retinal detachment surgery
- ☐ Retrobulbar mass
- ☐ Rhinoplasty - Cosmetic
- ☐ Rhinoplasty – Functional Only
- ☐ Scar Revisions or Repair
- ☐ Scalp Reductions
- ☐ Sclerotherapy (the injection of sclerosing agents) into the vertebral column
- ☐ Sex Change Surgery
- ☐ Silicone Injection
- ☐ Silicone Implant
- ☐ Sperm Banks for other than storage for insemination of your own patients
- ☐ Sphenopalatine Lesioning
- ☐ Spinal Infusion Pump – Implants
- ☐ Spinal Infusion Implants or Removal
- ☐ Spinal Infusion Pumps Refilling or Reprogramming
- ☐ Spinal Stimulation Implants
- ☐ Spinal Stimulation Programming
- ☐ Spinal Surgery
- ☐ Steroid injections for bursitis
- ☐ Suction Assisted Lipectomy (SAL) – Hips/Buttocks/Abdomens/Thighs*
- ☐ Suction Assisted Lipectomy (SAL) – Full Body*
- ☐ Suction Assisted Lipectomy (SAL) – limited to Head/Neck*
- ☐ Suction Assisted Lipectomy (SAL) – Eye Area*
- ☐ Suction Assisted Lipectomy (SAL) – Arms
- ☐ Surgery
- ☐ Surgery: Amputation (major)
- ☐ Surgery: Appendectomy
- ☐ Surgery: Bariatric
- ☐ Surgery: Biliary
- ☐ Surgery: Bunionectomy
- ☐ Surgery: Cardiac
- ☐ Surgery: Carpal tunnel release; # Per Year:_____
- ☐ Surgery: Closed Reduction; # Per Year:_____
- ☐ Surgery: Colon
- ☐ Surgery: Excisions of superficial lesions; # Per Year:_____
- ☐ Surgery: Ganglionectomy; # Per Year:_____
- ☐ Surgery: Hand ONLY
- ☐ Surgery: Hand - Arthrocentesis
- ☐ Surgery: Hand - Aspiration or Injection of Fingers, Wrist or Shoulder
- ☐ Surgery: Hand - Bone, tendon, nerve graft
- ☐ Surgery: Hand - Capsulectomy for joint stabilization
- ☐ Surgery: Hand - Capsulectomy or capsuloplasty for contracture
- ☐ Surgery: Hand - Complex Soft Tissue Repair; # Per Year:_____
- ☐ Surgery: Hand - Debridement/excision of nails not including the nail matrix or complicated nail bed reconstruction
- ☐ Surgery: Hand - Foreign body removal to include wire pin, screw, plate
- ☐ Surgery: Hand - Injection of tendon sheath, ligament or trigger point
- ☐ Surgery: Hand - Joint Replacement
- ☐ Surgery: Hand - Local flaps not including distant
- ☐ Surgery: Hand - Pedicle, free, etc.
- ☐ Surgery: Hand - Percutaneous or Internal Fixation
- ☐ Surgery: Hand - Scar revision
- ☐ Surgery: Hand - Skin graft
- ☐ Surgery: Hand - Synovectomy, tenosynovectomy
- ☐ Surgery: Hand - Tenovaginotomy for "Trigger" Finger; # Per Year:_____
- ☐ Surgery: Hand - Thenar Muscle Release for Contracture
- ☐ Surgery: Hand and Others
- ☐ Surgery: Herniorrhaphy
- ☐ Surgery: Herniorrhaphy (only inguinal, femoral epigastric or umbilical)
- ☐ Surgery: Implants - Type:_____
- ☐ Surgery: Incision of boil or superficial abscess
- ☐ Surgery: Injection treatment of varicose veins
- ☐ Surgery: Intestinal resection
- ☐ Surgery: Joint Replacement
- ☐ Surgery: Laminectomy
- ☐ Surgery: Laparoscopic Cholecystectomy
- ☐ Surgery: Lipectomy
- ☐ Surgery: Major Assist Only
- ☐ Surgery: Major
- ☐ Surgery: Mastectomy
- ☐ Surgery: Morton's neuroma; # Per Year:_____
- ☐ Surgery: Neurological – Other Major Procedures
- ☐ Surgery: Open Reduction
- ☐ Surgery: Organ transplant
- ☐ Surgery: Other Major Procedures
- ☐ Surgery: Percutaneious or Internal Fixation
- ☐ Surgery: Plastic, Cosmetic
- ☐ Surgery: Plastic, Reconstructive
- ☐ Surgery: Primary Extensor Tendon Repair (foot or hand); # Per Year:_____
- ☐ Surgery: Prostatectomy
- ☐ Surgery: Spinal Column
- ☐ Surgery: Submucous Nasal Resection
- ☐ Surgery: Thoracic
- ☐ Surgery: Total Joint Replacement
- ☐ Surgery: Thyroidectomy
- ☐ Surgery: Urological
- ☐ Surgery: Vascular
- ☐ Surgery: Weight Control
- ☐ Surgery: Weight Control, Intestinal Bypass
- ☐ Surgery: Weight Control, Other Abdominal Surgery
- ☐ Surgery: Suture Skin and Superficial Facia
- ☐ Surgery: Tenotomoy of Toes; # Per Year:_____
- ☐ Surgery: Tonsillectomy or Adenoidectomy
- ☐ Surgery: Transplants - Type:_____
- ☐ Surgery: Other:_____
- ☐ TAH/BSO
- ☐ Tattoo, tattoo removal or repair, cosmetic tattooing
- ☐ T & A's; # Per Year:_____
- ☐ Tendon Repair
- ☐ Therapeutic Radiology
- ☐ Thoracic Sympathectomies
- ☐ Trigeminal Lesioning
- ☐ Tubal ligation, post partum
- ☐ Tubal ligation, other
- ☐ Ultrasound – For Obstetrics
- ☐ Ultrasound - Other
- ☐ Use of chorionic gonadotropin in treatment of obesity
- ☐ Use of Laetrile (Amygdalin or Vitamin B-17)
- ☐ Vaginal delivery
- ☐ Vasectomy
- ☐ Vein Stripping*
- ☐ Vertebroplasty
- ☐ Weight control treatment - diet only
- ☐ Weight control treatment, non surgical
- ☐ Weight control drugs dispensing, (as opposed to prescribe)
- ☐ X-ray interpretation of chest, extremity, rib and clavicle films
- ☐ Other non-surgical: _____
- ☐ Wound Débridement

Insurance History:

73. If you are seeking prior acts coverage and will be the policyholder complete the following chart for **all** of your professional liability insurers during the prior acts coverage period. Begin with your most recent professional liability insurer.

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

74. 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 or 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

75. 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

76. Has any incident, claim, 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 75-77 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 your present insurer or nose coverage (prior acts coverage) from the Company to reduce the possibility of having a gap in coverage.

77. Has your 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 an entity. Each is subject to separate underwriting consideration.

INFORMATION REQUIRED - CHECKLIST

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

- ☐ Medical licenses.
- ☐ Curriculum vitae.
- ☐ Most recent certificates for completion (attendance) for continuing medical education programs.
- ☐ Authorization for release of information (page 12 of the application) signed by you.
- ☐ Completed Form A (page 13 of the application) for all claims, suits and incidents in the past 10 years. (If no claims, mark "0 claims" and sign)

***Supplemental applications are required for physicians practicing Anesthesiology, Bariatric Surgery, and Obstetrics as well as Locum Tenens.**

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.

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.

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.

Print Name of Applicant:_____

Signature _____ Date _____

Galen Insurance Company

Form A - Claim/Incident Report

Please complete for each suit, claim, or incident for which you responded yes in Questions 74-76 of the application. Please provide complete details in order to allow proper evaluation without the need for additional information. Attach copies of patient's charts, operative notes, or other documents as appropriate.

1. Name of patient:_____ Age:_____ Sex:_____

2. Type: ☐ Incident ☐ Request for records ☐ Demand for money or services ☐ Suit.

3. Date of incident:_____ Date Notified:_____ Location of incident:_____

4. Date Reported to Insurer:_____ Name of Insurer:_____

5. Allegation:_____
   _____
   _____

6. Condition/diagnosis at time of incident:_____
   _____

7. Dates/description of treatment rendered:_____
   _____

8. Other physicians, professionals or entities involved:_____
   _____

9. Disposition of claim:
   - ☐ Suit threatened, no action taken
   - ☐ Suit filed but dropped by claimant
   - ☐ Closed without payment
   - ☐ Summary judgment in your favor
   - ☐ Court outcome in your favor - ☐ jury verdict ☐ directed verdict
   - ☐ Court outcome in favor of plaintiff - ☐ jury verdict ☐ directed verdict, $_____ verdict amount
   - ☐ Settled out of court
     Date Claim Paid:_____
     Amount paid on your behalf: $_____
     Did you wish settlement of the claim? ☐ Yes ☐ No
   - ☐ Open - Status Pending: ☐ awaiting mediation/arbitration or ☐ awaiting court action
     Reserve Amount: $_____

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

Print name:_____ Date:_____

Signature:_____