GALEN
Insurance Company

# Renewal Application for Physicians and Allied Professionals

1. The applicant must complete or personally supervise the completion of this application.
2. Please answer each question or mark it not applicable.
3. If an explanation is required for any answer, please use the Comments section.
4. Please sign and date the completed application.

**INSURANCE COVERAGE IS SUBJECT TO UNDERWRITING APPROVAL AND FULL PAYMENT OF THE PREMIUM, OR AN AGREED UPON INSTALLMENT PLAN. NO COVERAGE EXISTS UNTIL THE INITIAL PREMIUM PAYMENT HAS BEEN MADE AND A DECLARATION PAGE, ALONG WITH ANY ENDORSEMENTS, HAS BEEN ISSUED TO THE POLICYHOLDER.**

**IF YOU HAVE ANY QUESTIONS REGARDING THIS APPLICATION, PLEASE CONTACT YOUR AGENT.**

1. Insured's Name: _____
   (First) (Middle) (Last)
2. Practice Name: _____
3. Practice Address: _____
4. Practice Phone: _____ Practice Fax: _____
5. Email: _____
6. Preferred Mailing Address: _____
7. What is your current medical specialty? _____
8. Are you board certified? ☐ Yes ☐ No If yes, what specialty: _____
9. DEA License Number: _____
10. Any new states added? Y N If yes list below:

| State | License # | Status | Expiration |
|---|---|---|---|
| | | | |

11. How many hours per week do you practice? _____
    If part-time, how many hours do you work weekly? _____

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

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

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

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

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

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

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

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

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

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

**The undersigned applicant hereby represents to Galen Insurance Company (the "Company") that all statements and explanations contained in this application and all attachments are true, complete and accurate, and that the applicant has not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application for professional liability insurance. The applicant agrees to notify the Company of any change in the information contained in this application or any attachment if the change occurs while this application is under review or after coverage begins, if a policy is issued. The applicant further agrees to be bound by, and subject to, the underwriting guidelines, policies, and procedures of the Company.**

**Comments: (Use a separate sheet if necessary)**

**Q#____ Comment**_____

**Q#____ Comment**_____

**Q#____ Comment**_____

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

Print Name of Applicant: _____

Signature: _____

Date: _____

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

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

Applicant's Signature_____Date:_____