

AMERICAN INTERNATIONAL COMPANIES®

Name of Insurance Company
To Which Application Is Made: (herein called the Company)

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION

This is an Application for Professional Liability coverage written on a claims made basis. Coverage is limited to liability for claims first made against an Insured and reported to use during the policy period or any applicable Extended Reporting Period Endorsement period immediately after the expiration of the policy period.

New Application Renewal Application

INSTRUCTIONS

- 1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, use the comment section or attach a separate page.
4. This application must be completed, dated and signed by each individual physician shareholder or employee of the entity.

GENERAL INFORMATION

1. Corporate Entity Name:
2. Address: Street City State Zip
3. Applicant Name:
4. Social Security Number: Date of Birth:
5. Address: Street City State Zip
6. Telephone Number: Fax Number:

PRACTICE PROFILE

- 7. Do you perform: (Please check all boxes that apply.)
Category 1: No surgical procedures performed other than incision of boils and superficial abscesses suturing of skin and superficial fascia or circumcision.
Category 2: Assist in surgery on your own patients
Category 3: Closed fractures - other than fingers and toes, D&C performed under local anesthesia, Vasectomies
Category 4: Obstetrical procedures and/or prenatal care beyond the first trimester not including Caesarian sections
Category 5: All other types of surgery
Category 6: Administration of anesthesia (other than local)

8. Indicate the percentage of time devoted to the following medical/surgical activities: (Total should equal 100%)

<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>
%	%	% Surgery
<input type="checkbox"/> Aerospace Medicine	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Abdominal
<input type="checkbox"/> Allergy	<input type="checkbox"/> Neurology	<input type="checkbox"/> Cardiac
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Broncho-Esophagology	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Colon & Rectal
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Obstetrics/Pre-Natal Care	<input type="checkbox"/> Dermatology
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> General
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Oncology	<input type="checkbox"/> Geriatrics
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Gynecology
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Hand
<input type="checkbox"/> Family Practice or	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Head & Neck
<input type="checkbox"/> General Practice	<input type="checkbox"/> Otorhinolaryngology	<input type="checkbox"/> Neonatal
<input type="checkbox"/> Forensic Medicine	<input type="checkbox"/> Pathology	<input type="checkbox"/> Neurology
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Obstetrics
<input type="checkbox"/> Gynecology	<input type="checkbox"/> Physical Medicine and	<input type="checkbox"/> Otorhinolaryngology
<input type="checkbox"/> Hematology	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Pediatric
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Perinatology
<input type="checkbox"/> Infectious Diseases	<input type="checkbox"/> Psychoanalysis	<input type="checkbox"/> Plastic
<input type="checkbox"/> Intensive Care Medicine	<input type="checkbox"/> Psychosomatic Medicine	<input type="checkbox"/> Plastic-Otorhinolaryngology
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Public Health	<input type="checkbox"/> Thoracic
<input type="checkbox"/> Laryngology	<input type="checkbox"/> Pulmonary Diseases	<input type="checkbox"/> Traumatic
<input type="checkbox"/> Legal Medicine	<input type="checkbox"/> Radiology	<input type="checkbox"/> Urological
<input type="checkbox"/> Neonatology	<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Vascular
<input type="checkbox"/> Neoplastic Diseases	<input type="checkbox"/> Rhinology	<input type="checkbox"/> Other _____

9. Please check the following medical techniques or procedures you perform:

- | | |
|---|---|
| <input type="checkbox"/> Acupuncture – other than acupuncture anesthesia | <input type="checkbox"/> ERCP (Endoscopic retrograde cholangiopancreatography) |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Lasers – used in therapy |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Myelography |
| <input type="checkbox"/> Catheterization – arterial, cardiac or diagnostic,
Other than: | <input type="checkbox"/> Needle Biopsy – including lung and prostate but not including liver, kidney, or bone marrow biopsy |
| a. Occasional emergency insertion of pulmonary Wedge, pressure recording catheters or Temporary pacemakers. | <input type="checkbox"/> Phlebography |
| b. Urethral catheterization | <input type="checkbox"/> Pneumatic or mechanical esophageal dilation (not with bougie or olive) |
| c. Umbilical cord catheterization for diagnostic Purposes or for monitoring blood gasses in Newborns receiving oxygen | <input type="checkbox"/> Pneumoencephalography |
| <input type="checkbox"/> Colonoscopy/Sigmoidoscopy lymphatics, sinus tracts and fistulae | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Cryosurgery - other than use on benign or Pre-malignant dermitological lesions | <input type="checkbox"/> Radioplaque dye injections into blood vessels, |
| <input type="checkbox"/> Discograms | <input type="checkbox"/> Shock therapy |

NONE OF THE ABOVE

10. School of Graduation: _____ Degree: _____ Month: _____ Year: _____

a. If a foreign medical school grad, do you have an ECFMG Certificate or a Fifth Pathway Certificate
 Yes No

Indicate which certification was obtained and year certified. ECFMG Fifth Pathway
 _____ Year Certified

b. Name and location where internship served. _____

c. Name and location where residency served. _____

d. Year residency completed: Month _____ Year _____ e. Residency specialty _____

11. Name all places where you have practiced in the last five years.

Places Of Practice	During Years

12. List all states where you are licensed to practice and license numbers.

State	License Number	% of Overall Practice In This State

13. Has there been any change in your specialty in the past five years? Yes No
 If "Yes", describe

14. How many continuing medical education credits did you achieve in the past year? _____

a. If you are not required to maintain continuing education credits as a prerequisite for licensing in your state, list all continuing education in which you have participated in the last three years. _____

15. Name and location of all hospitals where you hold staff or courtesy privileges.

Name of Institution	Location

16. Explain any "Yes" answers below on a separate sheet.

a. Are you engaged in any moonlighting activities? Yes No
 If "Yes", how many? _____

b. Has any hospital ever denied, restricted, suspended or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation ever been invoked? Yes No

- c. Has your narcotics or medical license ever been suspended, restricted, revoked or voluntarily surrendered or has probation been invoked? Yes No
- d. Have you been asked to participate in or have you volunteered to participate in an impaired physician program? (If "Yes", please attach a copy of your recovery plan document) Yes No
- e. Have you ever been denied a medical license or been denied certification by a specialty board? Yes No

CLAIMS HISTORY

- 17. a. Are you now, or have you ever been involved, directly, or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? Yes No
 - b. If "Yes", complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.
 - 18. a. Do you have knowledge of any claims, potential claims, or suits in which you may become involved, including without limitation knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim? Yes No
 - b. If "Yes", have these been reported to your present carrier? Yes No
 - Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.
 - 19. Has any similar insurance ever been declined, canceled, non-renewed, surcharged or conditioned? Yes No
- NOTE: MISSOURI APPLICANTS DO NOT RESPOND**
- If "Yes", give details (use additional sheet if necessary) _____
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The information requested is mandatory before a quotation can be promulgated.

The applicant represents the above statements and facts are true and that no material facts have been suppressed or misstated. Completion of this form does not bind coverage. Applicant's acceptance of company's quotation is required before applicant may be bound and a policy issued.

You agree to cooperate with the Company in implementing an ongoing program of loss-control and will allow the Company to review and monitor such programs that the hospital undertakes in managing its medical professional exposures.

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY

INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.”

NOTICE TO FLORIDA APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.”

NOTICE TO KENTUCKY APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.”

NOTICE TO MAINE APPLICANTS: “IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.”

NOTICE TO MINNESOTA APPLICANTS: “A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.”

NOTICE TO NEW JERSEY APPLICANTS: “ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.”

NOTICE TO NEW MEXICO APPLICANTS: “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.”

NOTICE TO NEW YORK APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.”

NOTICE TO OHIO APPLICANTS: “ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.”

NOTICE TO PENNSYLVANIA APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION SHALL UPON CONVICTION BE SUBJECT TO IMPRISONMENT FOR UP TO SEVEN YEARS AND PAYMENT OF A FINE OF UP TO \$15,000.”

Signature of Applicant: _____

Time: _____

Date: _____

Signature of Producer: _____

License #: _____

Date: _____