



6822 Delmar Blvd.
St. Louis, MO 63130
314-721-2366

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 THE COMPANY AT 314-721-2366.

1. Insured's Name: _____
2. Home Address: _____
3. Practice Name: _____
4. Practice Address: _____
5. Practice Phone: _____ Practice Fax: _____
6. Home Phone: _____ Email: _____

7. What is your current medical specialty? _____

8. Are you board certified? Yes No If yes, what specialty: _____
If not board certified, please explain on the Comments Page.

9. DEA License Number: _____

10. List the states in which you are licensed:

<u>State</u>	<u>License #</u>	<u>Status</u>	<u>Expiration</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. List the names of the states and counties in which you practice:

<u>State</u>	<u>County</u>	<u>Percentage of Practice</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. How many hours per week do you practice? _____

13. Are you full time or part-time? _____

If part-time, how many hours do you work annually _____

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

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

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

17. Are you a medical director for any facility? Yes No
If yes, do they provide your professional liability insurance? Yes No

18. During the past year, has any facility or organization limited or eliminated your privileges?
If yes, please explain on the Comments page. Yes No
19. 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?
If yes, please explain on the Comments page. Yes No
20. During the past year, have you become afflicted with any illness or physical condition that impairs or could impair your ability to practice medicine?
If yes, please explain on the Comments page. Yes No
21. During the past year have you been treated for alcoholism, mental illness, or narcotics addiction? If yes, please explain on the Comments page. Yes No
22. During the past year, have you become aware of any claim arising from your medical negligence? If yes, please describe on the Comments page. Yes No
23. During the past year, has any existing claim with a previous professional liability insurance carrier been resolved?
If yes, please provide a separate sheet with the details of the suit Yes No
24. 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 page. 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.

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

Print Name of Applicant: _____

Signature: _____

Date: _____

