



**7165 Delmar Boulevard Suite 215
St. Louis, Missouri 63130
Telephone: (314) 721-2366
Facsimile: (314) 721-2377**

**ALLIED PROFESSIONAL'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”, “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 applicant (“you”) of our response to this application.

Completion of Application

The applicant must personally complete 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 Part VII, the Comments Section, of this application. All questions should be answered based on the knowledge of, and information known to, 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 contained 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 AND RECEIVED AND A DECLARATION PAGE, TOGETHER WITH ANY ENDORSEMENTS THAT MAY APPLY, HAS BEEN ISSUED TO THE POLICYHOLDER.

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**ALLIED PROFESSIONAL
APPLICATION FOR
PROFESSIONAL LIABILITY
INSURANCE**

Please answer all questions fully and completely. PLEASE TYPE OR PRINT LEGIBLY.

PART I - GENERAL INFORMATION

1. Full Legal Name: _____
Include all names by which you have been known, and dates during which the name was used.
2. Date of Birth: _____
3. Male Female
4. License/Certificate: _____
5. SS#: _____
6. Are you a U.S. Citizen? Yes No; If no, please describe your current status, including your intentions regarding future citizenship: _____
7. Medical Field or job title: _____
8. Are you seeking coverage for prior acts? Yes No Retroactive date requested _____
9. Insurance limits requested: \$1,000,000 per claim / \$3,000,000 annual aggregate
 Other: _____ per claim / _____ annual aggregate

PART II - EDUCATIONAL HISTORY AND BOARD CERTIFICATION

1. Most Recent School: _____ Dates: From _____ To _____
City: _____ State: _____ Country: _____ Degree: _____
2. School: _____ Dates: From _____ To _____
City: _____ State: _____ Country: _____ Degree: _____
3. School: _____ Dates: From _____ To _____
City: _____ State: _____ Country: _____ Degree: _____
4. Other Training:
Name, location, and type: _____ Dates: From _____ To _____
Name, location, and type: _____ Dates: From _____ To _____
5. List the states in which you are currently licensed:
State: _____ License Type/No.: _____ Active? Yes No
State: _____ License Type/No.: _____ Active? Yes No
6. Identify all medical and professional societies to which you belong: _____

PART III - PRACTICE HISTORY

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

2. If you are in training, in your first two years of practice, or began practice in Missouri within the past two years, please attach three letters of recommendation.
3. List all locations (names and addresses) where you have been, are, or will be practicing:
 Present location: _____ Dates: From _____ To _____
 Present location: _____ Dates: From _____ To _____
 Prior location: _____ Dates: From _____ To _____
 Prior location: _____ Dates: From _____ To _____
4. Please explain any gaps in your training or practice: _____

5. How many category 1 credit hours of continuing medical education do you attend annually? _____
6. 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.
7. Do you work in an "urgent care" or similar setting? Yes No
 If yes, please provide complete details in Part VII of this application.
8. Do you perform any medical legal evaluations?..... Yes No
 If yes, for whom? _____
 What percentage of your practice does this entail? _____%
9. Do you have any teaching responsibilities?..... Yes No
 If yes, identity name and location of institution: _____
 Does this institution provide you with insurance coverage for your supervision? Yes No
 What percentage of your weekly time is spent supervising? _____%
 If insurance is not fully provided by the entity, please attach a copy of your contract or letter of agreement.
10. Do you employ or supervise any allied professionals?..... Yes No
 If yes, specify the number, role and type of allied professional.
- | <u>Number:</u> | <u>Employ or Supervise:</u> | <u>Type:</u> |
|----------------|-----------------------------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
11. Will you be performing activities that will be covered by another professional liability policy?..... Yes No
 If yes, please provide details, proof of coverage, include name and address of entity in Part VII of this application.
12. Do you treat prison or jail inmates?..... Yes No
 If yes, please provide complete details in Part VII of this application.
13. Are you employed by the United States Military Service?..... Yes No
14. Are you employed by the State of Missouri?..... Yes No
 If yes, indicate percent of time involved in private practice _____%
15. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunication, video, or information systems?..... Yes No

16. Do you perform consultation, read X-Rays, or interpret test results for physicians or organizations that render professional services in any manner including telemedicine in another state?..... Yes No
 If yes, please provide complete details in Part VII of this application, including name of state, number of hours per week practicing out of Missouri, the number of patients seen weekly, the number of diagnostic tests read and interpreted weekly, and the percentage of your total practice that is out of Missouri.

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

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

19. If yes to Questions 17 or 18, 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 coverage is not fully provided by the entity, please attach a copy of your contract or letter of agreement.

20. 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.

21. Do you serve on a trauma team? Yes No
 If yes, please provide complete details in Part VII of this application.

22. 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
 Walk-in patients _____ per week
Total _____ per week

23. 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

24. Do you practice any form of complementary and alternative medicine? Yes No
 If yes, please provide complete details in Part VII of this application.

25. Do you practice (or are you employed) 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.

26. 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 | # Per Year: _____ | Blepharoplasty – Cosmetic |
| Abortions – First Trimester; | Arteriography | Blepharoplasty - Functional |
| # Per Year: _____ | Assisting in Surgery – own patients | Blocks - Caudal Epidural |
| Abortions – Therapeutic | Assisting in Surgery – Patients of | Blocks - Celiac Plexus |
| Acupuncture, anesthesia | Others | Blocks - Cervical |
| Acupuncture, therapy | Autologous Fat Injection – Breast | Blocks - Cervical Epidural |
| Acupuncture, other | Autologous Fat Injection – Penis | Blocks - Differential Spinal |
| Amniocentesis | Bartholin cyst or abscess, I&D | Blocks - Facet Injection, Lumbar |
| Anesthesia – surgical | Biopsy, Breast, cyst aspiration | only, under Fluoroscopy |
| Anesthesia – caudal | Biopsy, Breast, excisional | Blocks - Facet Injection, other than |
| Anesthesia – epidural | Biopsy, Breast, incisional | Lumbar, under Fluoroscopy |
| Anesthesia - general | Biopsy, Breast needle | Blocks - Facet Joint Block |
| Anesthesia – Local | Biopsy , Cervical | Blocks - Lumbar |
| Angiography – lymph | Biopsy, Heart | Blocks - Lumbar Epidural |
| Angiography, other _____ | Biopsy, Liver | Blocks - Lumbar Sympathetic |
| Angioplasty | Biopsy, Skin | Blocks - Motor Point and Peripheral |
| Appendectomy: | Biopsy, Other _____ | 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
 Cesarean 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
 D&C; # Per Year: _____
 Dermabrasion/ Chemabrasion
 Dermatology
 Dermatology: Acne surgery
 Dermatology: Collagen injection
 Dermatology: Liposuction
 Dermatology: MOHS surgery
 Dilation and Curettage
 Digital Subtraction Angiography
 Dilation and Curettage
 Discograms
 Dorsal Column Stimulator
 Implant or Reprogram
 Electric Shock Therapy
 Electrosurgical Procedures

Endometrial Aspiration
 Endometrial Biopsy
 Endoscopy - Bronchoscopy
 Endoscopy, Colonoscopy
 Endoscopy, Esophagoscopy
 Endoscopy, Gastroscopy
 Endoscopy, Pelviscopy
 Endoscopy, Proctoscopy
 Endoscopy, Sigmoidoscopy, flexible to 65cm
 Endoscopy, Sigmoidoscopy, flexible to above 65cm
 Endoscopy, 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
 Fluoroscopy
 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
 Jejunio-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 prostate
 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
 Paraentesis
 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
 Prolotherapy without Phenol
 Radio Frequency Nerve Ablation
 Radial Keratotomy
 Radiation Therapy

Radiopaque 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 - Tenovagotomy 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: Percutaneous 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: Tenotomy 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

27. Do you provide services in connection with any surgery in your office? Yes No
 If yes, describe and include type of anesthesia (local, sedation, general): _____

28. Do you provide services in connection with any surgery in other non-hospital facilities? Yes No
 If yes, name the facilities and type of surgical procedures performed. _____
-
29. In the course of surgery described above, is general anesthesia administered?
 by you?..... Yes No
 by others?..... Yes No
30. Do you personally provide pre-operative exams and post-operative care for all surgical patients?..... Yes No
 If no, please explain: _____

PART IV - HOSPITAL AND OTHER AFFILIATIONS

1. Please list below all hospitals where you hold or are applying for privileges and the percentage of hospital time worked at each. Percentages should add up to 100%.

Hospital:_____	Privileges Type:_____	Time:_____%
Hospital:_____	Privileges Type:_____	Time:_____%
Hospital:_____	Privileges Type:_____	Time:_____%

2. Do you provide, or are you subject to providing, emergency care in a facility? Yes No
 If yes, is your work for your own patients only? Yes No
 Is your work required for staff privileges? Yes No
 Is there a written contract of agreement concerning your emergency care responsibilities?..... Yes No
 If provided at a facility (e.g., hospital, urgent care), is insurance coverage provided by the facility? Yes No
 Do you desire coverage for your emergency care services?..... Yes No
 If yes, please provide complete details of the emergency care services you provided in Part VII of this application.

3. Please provide the following information below or in Part VII of this application:
- (a) name of all medical service entities (including partnerships) and other health care-related service organizations in which you have an interest (e.g., ownership, employment, service contractor, etc);
 - (b) identify your interest or relationship (e.g., sole or partial owner, administrator, officer, teaching responsibilities, department director, etc.);
 - (c) the basis for your relationship (e.g., oral contract or written contract, if written contract, submit a copy);
 - (d) the number of hours per week you work in the above capacity(ies) for organization;
 - (e) whether malpractice insurance coverage is provided by the organization for your work there; and
 - (f) if malpractice coverage is not provided, whether coverage is sought. If coverage is being sought under this application, please provide full details of practice and professional services provided.

PART V - PERSONAL AND INSURANCE HISTORY

If you answer yes to the any of the following questions, please provide complete details in Part VII of this application.

- 1. 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
- 2. Have you ever been investigated, disciplined, censured, or reprimanded by a professional society or board or a licensing board? Yes No
- 3. Are there any restrictions on your current hospital privileges? Yes No
- 4. Has any hospital or other institution ever restricted, reduced, refused, or suspended your privileges or invoked probation? Yes No
- 5. Have you ever been under any hospital disciplinary observation, preceptorship, or sponsorship?..... Yes No

6. Have you ever voluntarily surrendered or had your license to prescribe or dispense narcotics refused, suspended, limited in any way, or revoked?..... Yes No
7. Are you now on probationary status? Yes No
8. 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
9. Have you ever voluntarily surrendered or had any state license to practice medicine refused, restricted, suspended, or revoked?..... Yes No
10. Have you ever been treated for alcoholism, mental illness, or narcotics addiction? Yes No
11. 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
12. 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.
13. 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.
14. In the last 10 years, have you had or are you aware of a claim, suit, or incident likely to become a medical malpractice claim?..... Yes No
If yes, please complete Form A attached for each claim, suit, or incident and submit the completed Form A with this application.
15. Were each of those claims, suits, or incidents reported to your malpractice insurer(s)? Yes No
If the incident was not reported to your malpractice insurer, please provide an explanation.

PART VI – INFORMATION REQUIRED - CHECKLIST

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

- Licenses and certifications.
- Curriculum vitae.
- Most recent certificates for completion (attendance) for continuing medical education programs.
- All written contracts concerning emergency care responsibilities.
- Authorization for release of information (see form attached) signed by you.
- Completed Form A for all claims, suits, and incidents in the past 10 years.

PART VII – 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.

Acceptance of advance payment does not bind the Company to provide insurance.

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.

The applicant hereby represents that he or she has listed all claims, suits, and incidents known to the applicant, or of which he or she should reasonably be aware, which would arise from the applicant’s acts or omissions which have occurred in the past ten years.

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.

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

Print Name of Applicant: _____

Signature _____ Date _____

Print Name of Proposed Policyholder (Group, if any): _____

An underwriter may contact the applicant for further information or clarification.

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 authorizes the Company to disclose to such persons, employers, institutions, boards or agencies any information about the undersigned or his or her practice or business that the Company determines to be necessary or appropriate in making its investigations and inquiries.

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.

Signature

Date

Printed Name

Galen Insurance Company

Form A - Claim/Incident Report

Please complete for each suit, claim, or incident for which you responded yes in Question 15 of Part V 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: _____