

THIS DOCUMENT IS NOT A BINDER OR ACCEPTANCE OF INSURANCE. Completion of this form, with or without payment of premium, does not bind the Galen Insurance Company ("Company") to issue insurance.

Please answer all questions fully and completely. If the applicant does not have enough space to provide a complete answer, please attach separate page(s) identifying the question number and providing the additional information necessary for a complete answer. PLEASE TYPE OR PRINT LEGIBLY. All questions must be answered. For questions that do not apply to the practice situation, please write "N/A" in the answer space provided. All questions should be answered based on the knowledge of, and information known to, the applicant. If additional forms are required or if a question arises about the application process, please call the Company at: 314-721-2366.

1. Applicant Name: _____ 2. Policyholder Name: _____
 3. Date of Birth: _____ 4. Social Security Number: _____

5. Which of the following procedures do you perform? Please indicate the % of Bariatric procedures.

	<u>Laparoscopic</u>	<u>Open</u>	<u>% of Bariatric Procedures</u>
a. Rouxen Y (RGB)	Yes	Yes	_____ %
b. Vertical banded gastroplasty	Yes	Yes	_____ %
c. Silicone ring vertical	Yes	Yes	_____ %
d. Adjustable Gastric Banding (AGB)	Yes	Yes	_____ %
e. Jejunioileal bypass	Yes	Yes	_____ %
f. BilioPancreatic Diversion (BPD)	Yes	Yes	_____ %
g. Duodenal Switch	Yes	Yes	_____ %
h. Revisions	Yes	Yes	_____ %
i. Other	Yes	Yes	_____ %

Describe Other: _____

6. Provide details of your training, education and certifications: _____

7. If you have completed any additional training the past two years for bariatric surgery, please include the details of training and certification: _____

8. Have you completed a preceptorship? Yes No
 If yes, list location and date: _____ Date: _____
 List type of program: _____
 List Number of Cases Reviewed: _____

9. Have you taken the ASBS Essentials Course? Yes No

10. Have you taken the ASBS Advanced Course? Yes No

11. How many years have you been performing bariatric surgery? _____

12. How many total bariatric procedures have you done in the past year? _____

13. Approximately how many bariatric procedures do you anticipate performing this policy year? _____

14. Approximately how many bariatric surgeries do you perform per week? _____

15. What percentage of your bariatric surgeries is performed on minors? _____

16. Does your hospital have defined credentialing guidelines for bariatric surgery? _____

17. Is the facility where you perform bariatric surgery equipped to accommodate larger patients (e.g. MRI, wheelchairs, exam tables, furniture, and transfer equipment) and staff trained to move and transport obese patients? Yes No

18. Please provide a list of all locations where you perform bariatric surgeries: _____

19. Do you use a multi-disciplinary approach? Yes No
Please provide any documentation.

20. How long is the post-surgical follow-up? _____

21. Please provide the number and percentage of bariatric cases during the preceding 24 months that had the following outcomes:

Outcome	Total # of Surgeries	% of Total
Inpatient Mortality*		
30 day Mortality*		
90 day Mortality*		
Revisions		
Transfer to other facilities		

* Provide date and cause

22. Please list the surgeons who provide coverage for your patients in your absence:

Name: _____
Bariatric Surgeon: Yes No Certified by the American Board of Surgery? Yes No

Name: _____
Bariatric Surgeon: Yes No Certified by the American Board of Surgery? Yes No

23. Please provide, along with this supplemental application, each of the following:

- a. a detailed description of your bariatrics risk management guidelines and procedures;
- b. a description of your established systems for pre-operative and post-operative care, including long-term patient follow up;
- c. documentation on your written protocols and procedures for your patient selection process/criteria (including minimum, maximum and average BMI); and
- d. a copy of your informed consent for bariatric procedures.

The undersigned applicant hereby represents to Galen Insurance Company (the "Company") that all statements and explanations contained in this supplemental 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 supplemental application for professional liability insurance. The applicant agrees to notify the Company of any change in the information contained in this supplemental application or any attachment if the change occurs while this supplemental 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.

Signature of Physician: _____ Date _____

Print Name: _____

An underwriter may contact you for further information or clarification.