

Galen Insurance Company
 7165 Delmar Blvd. Suite 215
 St. Louis, Missouri 63130
 Telephone: (314) 721-2366
 Facsimile: (314) 721-2377

**OBSTETRICS
 SUPPLEMENTAL APPLICATION
 FOR PROFESSIONAL LIABILITY
 INSURANCE**

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. Please provide information regarding your total deliveries in each of the following categories:

	Total Deliveries			Abortions
	High Risk	Normal Vertex	Cesarean Sections	
Anticipated next 12 months				
Last Year				
Two Years Ago				
Three Years Ago				
Four Years Ago				
Five Years Ago				

6. List specific obstetrical and fetal monitoring training. Attach documentation.

Date	Nature of Training	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Do you schedule all deliveries in a hospital? Yes No
 If no, please explain _____

8. Please identify the hospitals used for deliveries.

<u>Name:</u>	<u>Location:</u>	<u>Fetal Monitoring Equipment (Yes/No) Description and Year of Mfg:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. For each hospital listed above, identify and describe whether the following exist:

<u>24-Hour Availability of Anesthesia:</u>	<u>24-Hour Availability of Board Certified OBG</u>
_____	_____
_____	_____
_____	_____

10. What is the closest available referral hospital for complications?

<u>Name:</u>	<u>Location:</u>	<u>Mode of Transportation and Transport Time:</u>
_____	_____	_____
_____	_____	_____

- if you completed your residency within the last three years, a reference at the residency program who can confirm the level of obstetrics training included in the program; and
- the number of deliveries you have completed since finishing your residency with a statement of the complication rate and the number of patients requiring C-section.

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.