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

OPHTHALMOLOGY 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:____________________________

4. Please indicate whether your practice includes any of the following:
   - ☐ Conjunctival or Corneal Foreign Body Removal
   - ☐ Removal of Corneal Sutures
   - ☐ Minor Laceration Repair of Lids and Conjunctiva
   - ☐ Pterygium Removal in office setting
   - ☐ Anterior Segment Laser procedures (Capsulotomy, Iridotomy, Trabeculoplasty)

5. Please indicate whether your practice includes any of the following and, if so, the average number of procedures per year:

Procedure:	Average # Per Year
☐ Cataract Extraction	_______
☐ Posterior Capsule Laser	_______
☐ Radial or Transverse Keratotomy	_______
☐ Epikeratophakia	_______
☐ Keratomileusis	_______
☐ Photorefractive Keratectomy	_______
☐ Lasik and/or similar procedures	_______

6. Do you perform other procedures not listed above?..☐ Yes ☐ No
   If yes, please list: ____
   ____

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.