

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

**OTORHINOLARYNGOLOGY
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. Is your practice limited to E.N.T. office care (i.e., no surgery), which may include procedures such as flexible scope examination (as part of routine office exam without general anesthesia or biopsy)? Yes No
6. Have you or will you perform any of the following procedures (please check those applicable)? Yes No
 - Myringotomy
 - Tosillectomy and Adenoidectomy
 - Nasal Septoplasty (Limited to Nasal Fractures)
 - Polypectomy, Not Included Ethmoidectomy or Other Sinus Surgery
 - Limited Zyderm Collagen Injections
 - Cosmetic Ear Surgery
 - Staples Average Number per Year: _____
 - Tympanoplasty Average Number per Year: _____
 - Mastoidectomy Average Number per Year: _____
 - Inner Ear Surgery Average Number per Year: _____
 - Tracheostomy Average Number per Year: _____
 - Direct Laryngoscopy Average Number per Year: _____
 - Acoustic Tumor Surgery Average Number per Year: _____
7. Please list any other cosmetic procedures you have or will perform that are not listed on the application or this supplemental application: _____

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.