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

PLASTIC SURGERY 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 check those applicable to your practice and provide the number of procedures per year:

	Procedures:	# of Procedures per Year
☐	Complex Soft Tissue Repair	____________
☐	Scar Repair	____________
☐	Suction Aspiration of Lipoma	____________
☐	Dermabrasion	____________
☐	I & D of Subcutaneous Abscess or Cyst	____________
☐	Simple Soft Tissue Laceration Repair	____________
☐	Skin Lesion Excision with Flap or Graft Repair	____________
☐	Surgical Assisting	____________
☐	Skin Tumor Excision (benign or malignant)	____________
☐	Tattoo Repair	____________

6. Please check those applicable to your practice, where you perform them, and the average number you expect to perform per month:

		Office	Hospital	Other	Average Number Anticipated per Month
☐	Abdominoplasty	☐	☐	☐	____________
☐	Blepharoplasty	☐	☐	☐	____________
☐	Breast Augmentation/Reduction	☐	☐	☐	____________
☐	Breast Explanation	☐	☐	☐	____________
☐	Coronal Lift	☐	☐	☐	____________
☐	Face Lift (of any kind)	☐	☐	☐	____________
☐	Liposuction	☐	☐	☐	____________
☐	Mesotherapy	☐	☐	☐	____________
☐	Phenol Face Peel	☐	☐	☐	____________
☐	Prosthetic implantation or removal of any kind	☐	☐	☐	____________
☐	Rhinoplasty	☐	☐	☐	____________
☐	Rhytidectomy	☐	☐	☐	____________
☐	Scalp Reduction	☐	☐	☐	____________
☐	Suction-assisted Lipectomy*	☐	☐	☐	____________

*If training/residency was completed prior to 1983, submit proof of: (a) training through an approved symposium, and (b) hands on training.

7. Do you perform any of the following procedures?
   a. Autologous fat injection...☐ Yes ☐ No
      If yes, will you be injecting fat into the penis or breast?...☐ Yes ☐ No
   b. Chemical peel...☐ Yes ☐ No
      If yes, please specify types of solution you use:____

c. Do you or any of your non-medical staff members perform chemical peels?....☐ Yes ☐ No
If yes, are they: ☐ employees, or ☐ independent contractors

d.

Type of Peel	% Used	Performed By	
AHA	________	☐ physician	☐ ancillary
TCA	________	☐ physician	☐ ancillary
Phenol	________	☐ physician	☐ ancillary

Training: For AHA peels, certificates of training from the manufactures of the products to be used or the appropriate medical society must be provided. Summaries of experience in using peels should be provided for each. For Phenol and TCA peels, please also describe training.

e. Closed Capsulotomy ....☐ Yes ☐ No
 i. If yes, will you be performing closed capsulotomies in your private practice?....☐ Yes ☐ No
 ii. Do you obtain a separate informed consent for this procedure?....☐ Yes ☐ No
 iii. Will you perform the procedure on gel-filled implants? ....☐ Yes ☐ No

f. Aesthetic or Reconstructive Tattooing....☐ Yes ☐ No
 i. If yes, please advise where on the body: ________________________________
 ii. Does your staff perform cosmetic tattooing? ....☐ Yes ☐ No
 iii. If yes, please provide proof of training.

g. Malar Implants ....☐ Yes ☐ No

8. Do you perform:
 a. Penile or Scrotal Implants ....☐ Yes ☐ No
 b. Reconstruction of Breast ....☐ Yes ☐ No
  i. With Prosthesis....☐ Yes ☐ No
  ii. With Flap....☐ Yes ☐ No

9. Do you use electronic imaging?....☐ Yes ☐ No
 a. If yes, is a copy given to the patient? ....☐ Yes ☐ No
 b. Is a disclaimer used on the copy?....☐ Yes ☐ No
 c. If yes, please submit a copy of the disclaimer used.

10. Do you perform any of the following procedures?

	As Surgeon	As Assistant	No
a. Injection treatment of varicose veins	☐	☐	☐
b. Closed reduction of fractures except facial and/or hand	☐	☐	☐
c. Neurological surgery excluding nerve grafts	☐	☐	☐
d. Plating, pinning or open reduction of fractures other than facial and/or hand	☐	☐	☐
e. Orthopedic surgery above the wrist	☐	☐	☐
f. Ophthalmic surgery on orbital contents or globe	☐	☐	☐

11. Please check those applicable to your practice and provide the number of procedures per year:

☐ Bracheoplasty
☐ Open Breast
☐ Capsulectomy/otomy
☐ Buttock Implant
☐ Calf Implant
☐ Chin Implant
☐ Genioplasty
☐ Hair Flaps
☐ Injection Sclerotherapy of Cutaneous Ectasis
☐ Jaw Implant
☐ Laser Surgery of Vascular Lesions
☐ Mandibular Osteotomy
☐ Mastopexy
☐ Maxillary-zygoma Augmentation
☐ Nasal Implant/Augmentation
☐ Neckplasty (not as part of facelift)
☐ Osteomy (ies) of Maxilla
☐ Otoplasty
☐ Photofacial
☐ Rhinoplasty including
☐ Augmentation
☐ Skin Flap Reconstruction
☐ Skin Grafts
☐ Soft Tissue Augmentation (Gore-Tex, etc.)
☐ Superficial Chemical Peels (gycolic, Jessner, TCA 35% concentration or less, etc.)
☐ TCA 50% Peels
☐ TCA Peels (Augmented with CO2, AHA, methylsalicylate, factors 272, or Jessner's solution)

12. Indicate any other procedures (not listed above) you perform outside the range of usual plastic surgery procedures, and where they are performed.

____
____
____
____

13. Do you utilize any non-physician heath care providers, such as, but not limited to, medical assistants, nurses, or aestheticians for the performance of any procedures noted on this application?

If yes, please provide an explanation for when used and indicate whether the individual(s) are employed or independent contractors. Also, indicate if these individuals are physically located at your office and under your immediate supervision at all times or whether they are operating independently at a location other than an office where you are physically present at all times.

____
____
____

14. Where do you perform the procedures you have noted (check those that apply and complete the requested information)?
    ☐ Yes ☐ No - Non-surgical office setting
    ☐ Yes ☐ No - Surgical suite within office
    ☐ Yes ☐ No - Outpatient facility: Name of Facility: ______________________________
    ☐ Yes ☐ No - Hospital: Name of Hospital: ______________________________
    ☐ Yes ☐ No - Other: Specify:______________________________

15. For any of the facilities noted in Question 14, are patients kept overnight?.. ☐ Yes ☐ No

16. For any of the facilities noted in Question 14, please indicate any facility accreditation and licensure that apply:_______________
    ____

17. Do you use any conscious sedation or general anesthesia? .... ☐ Yes ☐ No
    If yes, who administers the anesthesia and who monitors and recovers the patient?______________________________
    ____
    If yes, is training or CME obtained annually or biannually in anesthesia administration?______________________________

18. If you perform procedures in your own office or free standing facility:
    a. Are you on staff at a hospital where the patient can be admitted for an overnight stay in case of an emergency?
    .... ☐ Yes ☐ No
    b. Do you have emergency and transfer protocols in writing?.. ☐ Yes ☐ No
    c. Are you and your staff ACLS certified? .... ☐ Yes ☐ No
    d. What resuscitative equipment do you have and maintain? ______________________________

19. Do you advertise your name, phone number and performance of the cosmetic procedures noted in any manner other than a one-line listing in the white or yellow pages? .... ☐ Yes ☐ No
    If yes, attach a sample of your display ad(s) and all other media advertisements. If you use radio or television, please attach a separate information sheet regarding these activities and include a copy of the script.

20. For each cosmetic procedure you perform, please provide the following information:
    a. evidence of training in the procedure to include any certificates of courses completed;
    b. patient selection protocol; and
    c. informed consent document.

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.