

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

**UROLOGY  
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. Will you or have you performed any of the following (please check those applicable)? .....  Yes  No

- Cystoscopy
- Urethral Dilation
- Urethroscopy
- Bladder Instillation
- Stent Removal (In-office)
- Catheter Insertion/Changes
- I & D of Superficial Abscess
- Lymphangiography
- Thoracentesis
- TURP
- Injection of Plaque (Peyronies Disease)
- Drainage / Injection of Hydrocele
- Trochar Suprapubic Cystotomy
- Needle biopsy - Average Number per Year: \_\_\_\_\_

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.