TDC Specialty Insurance Company
(hereafter, the "Underwriter")
A wholly owned subsidiary of The Doctors Company
Servicing Address: 1888 Century Park East, Suite 850
Los Angeles, CA 90067

Physicians Professional Liability Insurance Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Verify that all requested explanations and documents are attached, including current declarations page and policy, CV and currently valued loss runs.

- Please complete this form electronically or type/print clearly and answer all questions.
- If you do not purchase Prior Acts Coverage from us you will not have coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.
- If your specialty is Pain Management, Neurosurgery or Bariatric Surgery you will need to complete an additional procedure questionnaire.

ACCOUNT INFORMATION

1.	Applicant Name			
	Other Names Used			
	Gender	☐ Male ☐ Female		
	Degree / Title			
	Birth Date (MM/DD/YYYY)			
	Federal DEA #			
	National Practitioner ID #			
2.	Home Address	Street:		
		City:	State:	Zip:
		County:		
		Phone:	Fax:	
		Email:		
3.	Principal Office Address	Street:		
		City:	State:	Zip:
		County:		
		Phone:	Fax:	
		Email:		
		Website:		
4.	Other Office Address	Street:		
		City:	State:	Zip:
		County:		
		Phone:	Fax:	
		Website:		

5. Type of Practice (check all that apply):

☐Individual (solo) Unincorporated ☐Individual (solo) Corporation ☐Partnership

☐Member of Multi-Person Corporation or Association ☐Employee of: _____

☐Other (describe): _____ ☐Independent Contractor of: _____

6. List Federal Taxpayer Identification Number(s) and name(s) of Corporate entity(ies):

Entity: _____

Entity: _____

7. Please list names of all other partners, stockholders, associates, independent contractors and employed physicians. **(Indicate status of each and provide proof of coverage for each).**

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

FINANCIAL AND EXPOSURE DETAILS

8. List all states where the Applicant is licensed:

State: _____ License # _____
State: _____ License # _____
State: _____ License # _____

9. Medical Specialty: _____ % of practice: _____
Sub-Specialty: _____ % of practice: _____

10. Are you American Board Certified in your Specialty? ☐Yes ☐No

Name of Specialty Board(s):

Date of Certification: ____/____/____

11. Are you American Board Certified in your Sub-Specialty? ☐Yes ☐No

Name of Specialty Board(s):

Date of Certification: ____/____/____

12. If you are a foreign medical graduate, are you certified by the Educational Commission for Foreign Medical Graduates? ☐Yes ☐No

13. Have you ever failed any Board Certification testing? ☐Yes ☐No

If "Yes" please explain:

14. **Attestation**

If the answer to any of the following is "Yes," please give full details (including dates) on a separate sheet of paper:

a. Have you ever been or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? ☐Yes ☐No

If "Yes," provide copies of all accusations, decisions, consent orders, etc.

b. Has or is your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ☐Yes ☐No

c. Have you ever had privileges at any hospital or other institution denied, reduced, revoked, restricted or suspended? ☐Yes ☐No

d. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics or any other substance abuse, sexual addiction, anger management issues, or any mental or emotional disorder? ☐Yes ☐No

e. Have you ever been arrested, indicted, pled guilty to, or been convicted of any crime other than minor traffic violations? ☐Yes ☐No

f. Has your membership in any professional society or association ever been refused, censured, suspended or revoked? ☐Yes ☐No

g. Do you currently have or have you ever had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine? ☐Yes ☐No

h. Are you currently or have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform your professional duties? ☐Yes ☐No

i. Has any physician, patient or insurance plan ever filed a complaint against you with any Medical Association/Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau? ☐Yes ☐No

j. Have you ever been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)? ☐Yes ☐No

15. **Training**

Medical School: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Internship:

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Type of Residency: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Fellowship Training /Type: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Additional Medical Specialty training

Location	Type	Dates

16. Do you perform surgery:
    a. In your office? ☐Yes ☐No
    b. In any other non-hospital facility? ☐Yes ☐No
    If "Yes" list the names and type of facilities:

    List the surgical procedures you perform in your office or other non-hospital facility:

    c. Is general anesthesia administered in any of the above non-hospital facilities? ☐Yes ☐No
    If "Yes," by whom?

17. Do you treat or review the treatment of prison inmates? ☐Yes ☐No
    If "Yes:"
    a. What percentage of your practice? _____ %
    b. Please explain and provide facility names:

    c. Is insurance provided by the above facility? ☐Yes ☐No

18. Do you practice as a professional or amateur sports team physician? ☐Yes ☐No
    If "Yes,"
    a. What percentage of your practice? _____%
    b. Describe duties, team names and type of sport:

19. Do you perform medical legal evaluations? ☐Yes ☐No
    If 'Yes,"
    a. What percentage of your practice? _____%
    b. For whom?

20. Do you treat or consult on patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands? ☐Yes ☐No
    If "Yes:"
    a. What percentage of your practice? _____%
    b. Where?

21. Are you associated in any capacity with, or do you have a financial relationship (ownership, investment or compensation) with, any of the following:

a. Any health care facility having bed and board accommodations? ☐Yes ☐No

b. Any surgicenter, clinic, urgent care center, foundation, blood bank, laboratory, abortion clinic, birthing center, physical, occupational or speech-language therapy services, radiology/imaging services, radiation therapy services, durable medical equipment/supplies, prosthetic or orthotic devices/supplies, home health services, or outpatient prescription drugs? ☐Yes ☐No

If "Yes" to either of the above, are you:

☐Owner (whole or part) ☐Executive Officer ☐Director of Ancillary Services Dept.
☐Administrator ☐Medical Director ☐Committee Member
☐Other (describe):

c. Any other medically related business enterprise? ☐Yes ☐No

If "Yes," please explain:

22. Are you a physician with teaching responsibilities? ☐Yes ☐No

If "Yes:"

a. Please explain:

b. Is insurance coverage provided by this institution or facility? ☐Yes ☐No

23. List all facilities (i.e. hospitals, surgicenters, etc.) where you are currently on staff and show percentage of work in each facility:

Facility Name	City	State	Type of Privileges	% of Work

24. Are you a Hospitalist? ☐Yes ☐No

If "Yes," at what facilities?

25. Do you:

a. Work in any emergency room? ☐Yes ☐No

If "Yes," is it required solely to maintain staff privileges? ☐Yes ☐No

b. Provide any Locum Tenens services? ☐Yes ☐No

c. "Moonlight" at any facilities? ☐Yes ☐No

d. Provide any services at a hotel, spa or health club? ☐Yes ☐No

e. Provide pre or post-operative care or follow-up for any bariatric surgery patients? ☐Yes ☐No

If "Yes," percent of practice? _____%

If "Yes," to any of the above, please explain:

26. Do you treat patients in any nursing home, skilled nursing facility or assisted living center? ☐Yes ☐No

If "Yes:"

a. What percent of practice? _____%

b. Do you treat patients other than your own? ☐Yes ☐No

27. What percentage of your practice involves the treatment of chronic pain management with medications only? _____%

28. As part of your practice do you diagnose, treat, care for or consult with patients regarding the use of medical marijuana? ☐Yes ☐No

If "Yes," please explain:

29. Are you associated with any clinics that dispense medical marijuana? ☐Yes ☐No

If "Yes" please explain:

30. Are you a medical director of any facility? ☐Yes ☐No

If "Yes," what facility?

If "Yes, provide evidence of coverage for each facility.

31. Do you perform consultations outside the state of your primary office address, including but not limited to, the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (tele-medicine or internet medicine) or do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? ☐Yes ☐No

If "Yes:"

a. What percentage of your practice? _____%

b. Identify all states in which such patients reside:

32. Do you treat patients who reside outside the state of your primary office address? ☐Yes ☐No

If "Yes" what percentage of your practice? _____%

What states?

33. Do you have any other practice outside of what you are applying for coverage? ☐Yes ☐No

If "Yes,"

a. Name of practice: _____

b. Name of Carrier: _____

34. List all locations where you have practiced in the last 10 years (include time period, group name and address).

Group Name	Street/City/State	During Years

35. How many:
    a. Days do you work per week? _____
    b. Hours do you work per day? _____
    c. How many surgical procedures do you perform each week? _____

36. What is your average weekly patient load? _____

37. What percent of your patients are:
    a. Over age 65? _____%
    a. Age 18 or younger? _____%
    b. Hospitalized patients? _____%

38. Do you or your professional entity employ or contract for the services of any healthcare personnel? ☐Yes ☐No

If "Yes," provide number of each and indicate if coverage (shared limits) is desired for each.

(Note: If employed by an entity, coverage may not be available.)

	Full-Time / Part-Time	# Employed	Is Coverage Desired?	# of Independent Contractors	Are they Insured?
Nurses (RN, LPN, LVN)					
Medical Assistants					
Technicians					
Psychologists					
Physical Therapists					
Physicians Assistants**					
Nurse Practitioners**					
CRNA's**					
Nurse Midwives**					
Other (describe):					
Other (describe):					

**If employed or contracted, please submit a written explanation of practice and procedures performed, along with certificate of course completion and license number. Provide proof of insurance if insured elsewhere. If coverage is desired, please complete an Allied Personnel Professional Liablity Insurance Application for each.

39. Do you advertise your medical practice? ☐Yes☐No

If "Yes:"

    a. In what states?

    b. List medium(s) and frequency of each:

    c. Provide copies of advertisements that you are currently using or have placed in periodicals, yellow pages, on flyers, handouts, etc. and any scripts being used for voice or film media.

40. Do you use experimental devices or drugs or do you perform experimental procedures or therapy in treatment or surgery or are you a principal investigator for any clinical trial? ☐Yes☐No

If "Yes:"

    a. Provide details:

    b. Are the protocols IRB approved? ☐Yes☐No
    c. Are you involved or do you participate in non-IRB approved clinical research trials? ☐Yes☐No
    If "yes," please provide full details on separate sheet and include supporting documents.

41. Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule? ☐Yes☐No

If "Yes," have you implemented procedures to comply with the HIPAA Privacy Rule? ☐Yes ☐No

42. Has your practice (e.g. specialty, procedures or practice environment) changed in the last five years? ☐Yes☐No

If "Yes," please explain:

43. For each procedure below, please provide the approximate number of times you have "Performed" or "Assisted" during the past 12 months as well as how many times you anticipate doing so during the next 12 months. If you Perform or Assist in other procedures not listed below, add each one under "Other" in each section.

A. General Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Alternative/Holistic Medicine (explain): _____				
Angiography				
Angioplasty				
Anti-Aging Medicine (explain): _____				
Arterial Catheterization				
Arteriography				
Bronchoscopy				
CCU Care (other than admitting)				
Chelation Therapy (explain): _____				
Chemotherapy				
Colonoscopy				
Cardiac Catheterization				
Cardiac Cath – Right Heart Only				
Cryosurgery (explain): _____				
Dialysis Procedures				
Elective Cardioversion				
Endoscopy (explain): _____				
Hair Transplants				
Hypnosis				
IVP				
Laser Therapy (explain): _____				
Lymphangiography				
Myelography				
Paracentesis or Thoracentesis				
Polypectomy by Endoscopy				
Venography				
Weight reduction or Weight Control If "Yes," % of practice: _____ List methods, drugs prescribed on a separate sheet of paper				
Other (describe): _____				
☐ None of the above				

B. Gynecology Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Abortions – Your Patients				
1st Trimester				
After 12 weeks				
Therapeutic				
Elective				
Abortions – Other Patients				
1st trimester				
After 12 weeks				
Therapeutic				
Elective				
Attach list of facilities where you perform abortions.				
A&P Repair				
Cervical Cautery				
Cold Conization Cervix				
Culdocentesis				
Dilation & Curettage				
Ectopic Pregnancy				
Hysterectomy – Vaginal				
Hysterectomy – Abdominal				
Insertion of IUD				
In Vitro Fertilization If 'Yes," % of practice:_____				
Laparoscopy				
Office Gynecology				
Oophorectomy or Salpingectomy				
Tubal Ligation				
Other (describe): _____				

Do you own or operate a sperm bank for
the treatment of your patients? ☐ Yes ☐ No
the treatment of others' patients? ☐ Yes ☐ No

☐ None of the above

C. Pediatric Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Circumcisions				
Neonatology				
If "Yes," % of practice: _____				
Umbilical Catheterization & Monitoring				
Other (describe): _____				
☐ None of the above				

D. Obstetrical Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Amniocentesis – 3rd Trimester Only				
Amniocentesis – 1st & 2nd Trimester				
Breech Delivery				
Cesarean Sections				
Episiotomy				
Low Forceps				
Managing Toxemia				
Mid Forceps				
Normal Deliveries				
Prenatal Care				

E. Surgical Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Adenoidectomy				
Anal Fissure				
Anal Fistulectomies				
Any surgical procedure involving cutting into or within the abdominal cavity, chest cavity, orbital cavity, spine or facial sinuses				
Any surgical procedures on malignant lesions except for diagnostic purposes				
Amputations				
Appendectomies				
Aspiration of Cyst of Breast				
BCIR				
Biopsies If "Yes," explain types: _____				
Cholecystectomies – Open				
Chymopapian Injections				
Hemorrhoidectomies				
Hernioplasties				
Herniorrhaphy (Inguinal or Femoral Only)				
Laparoscopic Cholecystectomies				
Mastectomy				
Mastoidectomy				
Minor Office Surgery				
Myringotomy				
Nasal Polypectomy				
Operations within the middle or inner ear				
Organ Transplants If "Yes," explain: _____				
Otorhinolaryngology				
Peripheral Nerve Surgery				
Prostatectomy				
Reconstructive Vascular Surgery, Thromboembolectomy and/or Thrombectomy of the arteries or veins				
Repair of laceration not involving nerve or tendon				
Submucous Nasal Resections				
Surgical treatment of cysts, superficial abscesses, minor traumatic wound & superficial biopsies				
Surgical Weight Reduction				
If "Yes," complete a Bariatric Surgery Questionnaire				
Thyroidectomy				

Home Deliveries				
Other Non-Hospital Deliveries (explain): _____				
VBAC				
Other (describe): _____				
☐ None of the above				

F. Urological Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Any cutting into or on the kidney, ureter or bladder				
Aspiration of Hydrocele				
Circumcisions				
Orchiectomy				
Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)				
Prosthetic Implants				
Sex Change Surgery				
Treatment of Torsion of the Testicle				
Vasectomy				
Other (describe): _____				
☐ None of the above				

G. Anesthesia Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Acupuncture				
If "Yes," for anesthesia?				
Caudal				
Digital Block				
General				
Intravenous Anesthesia Intravenous Analgesia				
Nitrous Oxide				
Obstetrical Anesthesia				
Pain Blocks				
Pain Management If "Yes," please complete a Pain Management Questionnaire				
Peripheral Nerve Block				
Spinal Anesthesia				
Other (describe): _____				

If "Yes" for any Anesthesia type, check locations where performed:
☐ Hospital ☐ Surgicenter ☐ Non-hospital facility

Do you perform Anesthesia for any Genital Cosmetic Surgery Procedures? ☐ Yes ☐ No

Do you perform Anesthesia for any Bariatric Surgery Procedures? ☐ Yes ☐ No

Do you employ any inhalation therapists? ☐ Yes ☐ No

	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Tonsillectomy				
Vein Stripping				
Other (describe):				
_____				
☐None of the above				

H. Plastic & Cosmetic Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Autologous Fat Injection				
Blepharoplasty (cosmetic)				
Botox Injections				
If "Yes," where are, by whom and what procedures are performed?				
_____				
_____				
Breast Reduction				
Breast Enhancement – Silicone				
Breast Enhancement – Saline				
Breast Enhancement – Trans-Umbilical				
Chemical Peels				
Collagen Injections				
Coronal Lift				
Dermabrasion				
Hair transplants or suturing of hair pieces				
Injection Treatment of Varicose Veins Laser Therapy (explain):				
_____				
Laser vaginal rejuvenation (includes cosmetic and /or plastic surgery procedures performed on the vagina and associated structures. This includes, but is not limited to vaginoplasty, labiaplasty, laser and non-laser rejuvenation procedures)				
Other Surgical Procedures (explain):				
_____				
Liposuction – under 3500 cc's				
Liposuction - 3500 cc's or more				
Phalloplasty – including transecting the suspensory ligament of the penis and/or subcutaneous fat injection				
Rhinoplasty				
Silicone Implants (types and where)				
_____				
_____				
Silicone Injections				
Other (describe):				
_____				
☐None of the above				

Have you assumed supervisory duties over:
Nurse Anesthetists? ☐ Yes ☐ No
Inhalation Therapists? ☐ Yes ☐ No
☐None of the above

I. Orthopedic & Neurosurgical Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Any operative orthopedics				
Arthroscopy or Arthrography				
Injection of Bursa				
Joint Implants				
Neuro Implant Surgery for Pain				
Open Reduction of Fractures				
Prolotherapy				
If "Yes," do you use Phenol? ☐ Yes ☐ No				
Repair of Extensor Tendon				
Repair of Flexor Tendon				
Spinal Surgery				
Anterior Cervical Discectomies				
Cervical Laminectomies				
Pedicle Screw				
Scoliosis Surgery				
Stereotactic Neurosurgery				
Other (describe):				
_____				
☐None of the above				

J. Ophthalmology Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Automated Lamellar Keratotomy				
Blepharoplasty (Cosmetic)				
Blepharoplasty (Functional)				
Cataract Surgery				
Chalazion Excision from Eyelids				
Corneal Transplants				
Enucleation				
Hexagonal Keratotomy (HK)				
Intraocular Lens Implant				
Iridectomy				
LASIK				
Lid-Repair – Ectropion & Entropion				
Photo-Refractive Keratotomy (PRK)				
Pterygium Excision				
Refraction's				
If "Yes," what type?				
_____				
Removal of Eyelid Lesion				
Retinal Detachments				
Trabeculectomy				
Treatment of Eye Infection				
Other (describe):				
_____				
☐None of the above				

CURRENT AND REQUESTED COVERAGE

44. **MISSOURI RESIDENTS - DO NOT ANSWER.**

Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant? ☐Yes ☐No

If "Yes," please provide details:

45. Requested Effective Date of Coverage: Requested Retroactive Date of Coverage:

46. Do you intend to purchase a reporting endorsement (aka Tail Coverage) from your current insurer? ☐Yes ☐No

If "No," do you wish to obtain Prior Acts Coverage from us? ☐Yes ☐No

If applying for Prior Acts Coverage, please attach a copy of your most recent Declarations page and Policy (Prior Acts coverage is subject to Underwriter approval)

47. List malpractice coverage for the past 10 years, beginning with your current or most recent carrier:

Carrier	Limits	Policy Period MM/DD/YYYY – MM/DD/YYYY	Claims Made or Occurrence	Retroactive Date (if applicable)	Premium

CLAIMS HISTORY

48. In the past, has the Applicant or any entity or individual proposed for coverage under this insurance, received or been involved in any claim, suit or medical incident that may fall within the scope of the proposed insurance? ☐Yes ☐No

If "Yes," please complete a **Claims Information Form** for each claim, suit or medical incident.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM, SUIT OR MEDICAL INCIDENT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 48 IS EXCLUDED FROM THE PROPOSED INSURANCE.

49. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance? ☐Yes ☐No

If "Yes," please complete a **Claims Information Form** for each fact, circumstance, situation, transaction, event, act, error or omission.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 49 IS EXCLUDED FROM THE PROPOSED INSURANCE.

CLAIMS INFORMATION FORM

(Please make additional copies if needed)

1. Name of Patient: 2. Age: 3. Gender: ☐M ☐F

4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon):

5. Date of Incident: 6. Date Reported to Carrier: 7. Location:

8. Insurance Carrier(s):

9. Other Defendant(s):

10. Plaintiff's Counsel:

11. Defendant's Counsel:

12. Status: ☐ Incident Only ☐ Suit ☐ Closed If Closed, Date Closed:
Amount Paid: ☐ Settlement ☐ Judgement

13. Allegation(s) (as stated by patient/plaintiff):

14. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? ☐Yes ☐No

15. Condition and diagnosis at time of treatment:

16. Dates and description of treatment rendered:

17. Condition of patient subsequent to treatment (include DATES & FOLLOW UP TREATMENT):

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: X _____ Date: _____

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARKANSAS, MINNESOTA AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS AND WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MISSOURI APPLICANTS: Any person commits a "fraudulent insurance act" if such person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) no more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy. The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITITES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____ City: _____ State: _____ Zip: _____
Email Address	
Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____ City: _____ State: _____ Zip: _____

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.