ProAssurance
Treated Fairly

Excess & Surplus Lines Division

HEALTH CARE PROFESSIONAL LIABILITY INSURANCE APPLICATION
PHYSICIANS AND SURGEONS

With your fully completed, signed and dated application, you ***must*** submit the following information:

1. Current insurance policy declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made.
3. Current business letterhead.
4. Copy of all licenses and board certifications.
5. Currently valued loss runs from all prior insurance companies.
6. Copy of curriculum vitae.
7. Articles of Incorporation, if applicable.

NOTE: ***SUBMISSION OF A COMPLETED APPLICATION CONFERS NO OBLIGATION UPON THE COMPANY TO BIND COVERAGE.***

P.O. Box 590009
Birmingham, Alabama 35259-0009
(205) 445-2600 / (800) 282-6242

NOTE: If any space provided herein is insufficient for complete reply, please use Page 13, and/or a separate sheet, identifying by number the questions you answer.

1. PERSONAL INFORMATION

Full Name of Applicant: _____ ☐MD ☐DO ☐ _____
FIRST MIDDLE LAST SUFFIX

Date of Birth: _____ Gender: _____ Place of Birth: _____
MONTH DAY YEAR

Social Security Number: _____ Home Phone: ( ) _____

Home Address: _____

_____
CITY COUNTY STATE ZIP

2. OFFICE INFORMATION

Principal Office Address: _____

_____

_____
CITY COUNTY STATE ZIP

Please check this box if your Principal Office Address is <u>not</u> actually located within the city limits of the city to which your mail is addressed. ..... ☐

Office Phone Number: ( ) _____ Office Fax Number: ( ) _____

Secondary Office Locations (if any): _____

_____

_____
CITY STATE ZIP

Secondary Office Phone No.: ( ) _____ Secondary Office Fax No.: ( ) _____

Preferred Billing Address: ☐ Principal Office ☐ Secondary Office ☐ Home

Preferred Contact Person: _____ at ☐ Principal Office ☐ Secondary Office

Percentage of practice at each of the above locations: _____ Principal Office _____ Secondary Office

E-mail Address(s): _____

3. EDUCATIONAL INFORMATION

MEDICAL SCHOOLS			
NAME OF MEDICAL SCHOOL(S) ATTENDED	LOCATION OF SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING					
INSTITUTION	LOCATION	SPECIALTY OR DEPARTMENT	DATES (MONTH/YEAR) START	END	COMPLETED? CIRCLE ONE
					YES NO*
					YES NO*
					YES NO*
					YES NO*

* IF "NO" CIRCLED, EXPLAIN FULLY ON PAGE 15 OR A SEPARATE SHEET

CATEGORY I CONTINUING MEDICAL EDUCATION COMPLETED IN PAST THREE YEARS		
COURSES COMPLETED	CREDITS RECEIVED	DATES ATTENDED
List all others on page 15		

4. PRACTICE HISTORY

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY		
LOCATIONS	DATES (MONTH/YEAR)* START	END
*PROVIDE BRIEF DESCRIPTION OF EACH PRACTICE SITUATION, INCLUDING CLINICAL RESPONSIBILITIES, AND EXPLAIN ANY GAPS IN PRACTICE ON PAGE 15 OR A SEPARATE SHEET		

5. LICENSING AND BOARD CERTIFICATIONS

A. Licensing (List all states in which you are currently licensed.)

STATE	LICENSE NUMBER	% OF PRACTICE	WHICH COUNTY?	MEMBER OF STATE MEDICAL ASSOCIATION?
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

B. If you are a foreign graduate, are you certified by the Educational Commission for Foreign Medical Graduates? ..... YES ☐ NO ☐

C. Are you American Board Certified? ..... YES ☐ NO ☐

i. If "yes," list Specialty Board(s): _____ (Indicate allopathic or osteopathic)

ii. If "yes," list date of initial Board Certification: _____

iii. If applicable, list date of re-certification(s): _____

iv. If "no," are you Board eligible? ..... YES ☐ NO ☐

v. If Board eligible, when do you plan to take your Boards? _____

6. PRACTICE ORGANIZATION

A. Please check all that apply and provide details. If vicarious liability coverage is desired, so indicate.

☐ Solo Entity: Name _____

Corp. Tax ID # _____ Date of Incorporation _____ ☐ Coverage Requested

☐ Member of a partnership or multi-shareholder corporation: _____

Partnership/Group Name _____

Corp. Tax ID # _____ Date of Incorporation _____ ☐Coverage Requested

☐Other - please explain:_____

Entity Name _____

Corp. Tax ID # _____ Date of Incorporation _____ ☐Coverage Requested

Please include Articles of Incorporation and any amendments, a list of principals, and a copy of your business letterhead.

B. Give the full names of all other physicians affiliated with any organization(s) named in Question 6A, above. Use Page 15, if necessary.

NAME	CURRENT PROFESSIONAL LIABILITY INSURANCE CO.

7. HOSPITAL AFFILIATIONS AND PRIVILEGES

HOSPITALS WHERE YOU HAVE, OR HAD, ACTIVE PRIVILEGES OR WHERE YOU HAVE APPLIED					
HOSPITAL DATA		DATES (MONTH/YEAR)		% OF YOUR PATIENTS ADMITTED TO THIS FACILITY	ISSUE CERTIFICATE OF INSURANCE? (CIRCLE ONE)
NAME	MAILING ADDRESS	START	END		
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO

8. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

A. List below any of the following professionals associated with your practice:

Anesthesia Assistants, Certified Registered Nurse Anesthetists, Cytotechnologists, Emergency Medical Technicians, Nurse Practitioners, Nurse Midwives, Optometrists, Perfusionists, Physician Assistants, Psychologists, Surgeon's Assistants.

Please indicate if coverage is desired for these individuals. A separate application will be required for each individual for whom coverage is requested.

NAME	SPECIALTY	EMPLOYMENT STATUS	TO BE CONSIDERED FOR SHARED LIMITS COVERAGE?
		☐Employee ☐Contractor	☐Yes ☐No
		☐Employee ☐Contractor	☐Yes ☐No
		☐Employee ☐Contractor	☐Yes ☐No
		☐Employee ☐Contractor	☐Yes ☐No
		☐Employee ☐Contractor	☐Yes ☐No
		☐Employee ☐Contractor	☐Yes ☐No

B. If you employ a Nurse Midwife, how many deliveries does that individual perform annually? If more than one midwife, respond for each separately._____

_____

C. Indicate the number of the following types of employees who provide services in your office:

NUMBER	POSITION	NUMBER	POSITION
	Medical Assistant		Nurse (Registered or Licensed Vocational)
	Psychotherapist		Technician (Lab, Pathology, Dialysis, etc.)
	X-Ray Technician		Other:

D. Do any of your employees practice at a location geographically separate from yours?..... YES ☐ NO ☐

If "yes," please explain. _____

_____

9. PROFESSIONAL LIABILITY INSURANCE HISTORY

NAME OF COMPANY (CURRENT)	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	☐ CLAIMS-MADE ☐ OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	☐ CLAIMS-MADE ☐ OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE: RETROACTIVE DATE:	☐ CLAIMS-MADE ☐ OCCURRENCE

A. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage?..... YES ☐ NO ☐

B. If the Company does not offer you prior acts coverage, will you purchase "tail" coverage from your current carrier? If not, please explain on page 15..... YES ☐ NO ☐

C. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? If "yes," please provide complete explanation on page 15..... YES ☐ NO ☐

Important information regarding questions 9D and 9E (including sub-questions)

1. The word "claim" as used in questions 9E and 9F following refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to any parts of questions 9D or 9E, please complete the attached Supplementary Claims Information Form on page 16 for all such claims.

D. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? .... YES ☐ NO ☐

If "yes," how many? _____ Please provide details for each on page 16.

E. Other than the claims/suits indicated in 9D, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?

i. A request for records from a patient and/or attorney related to an adverse outcome?... YES ☐ NO ☐

ii. A letter from an attorney regarding your medical treatment of a patient?..... YES ☐ NO ☐

iii. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability or the need for follow-up surgery?..... YES ☐ NO ☐

iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? ..... YES ☐ NO ☐

v. Any other circumstances that might reasonably lead to a claim or suit? ..... YES ☐ NO ☐

vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ..... YES ☐ NO ☐

a. If "Yes", how many? _____ Please attach documentation of all such reports.

b. If "No", please explain on page 15.

For purposes of this question, check the following box if you are aware of no circumstances that might reasonably lead to a claim or suit. .....Not Applicable ☐

If you answer "yes" to questions 9F through 9O, please provide details on page 15.

F. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ..... YES ☐ NO ☐

G. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? ..... YES ☐ NO ☐

H. Have you ever failed any licensing or Board Certification examinations? ..... YES ☐ NO ☐

If yes, how many times? .....

I. Have you ever been refused hospital privileges? ..... YES ☐ NO ☐

J. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? ..... YES ☐ NO ☐

K. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? ..... YES ☐ NO ☐

L. Have you ever been convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? ..... YES ☐ NO ☐

M. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? ..... YES ☐ NO ☐

N. Have you ever been accused of sexual misconduct of any kind?..... YES ☐ NO ☐

O. Do you have any physical handicap or any chronic illness? ..... YES ☐ NO ☐

P. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors or public health insurance payors, including, but not limited to, Medicare or Medicaid? ..... YES ☐ NO ☐

If "yes," explain in detail on page 15 including the date(s) and resolution, if any. _____

10. COVERAGE REQUEST

Requested Effective Date: _____
MONTH DAY YEAR

A. Please indicate your desired level of coverage by placing an "X" in the appropriate box.

☐ $100,000 / $300,000 ☐ $200,000 / $600,000 ☐ $250,000 / $750,000

☐ $500,000 / $1,500,000 ☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $6,000,000
(Available only in the state of Virginia)

B. A deductible of at least $5,000 is required. Please select any optional deductible that you desire. No aggregate limitation will apply to the deductible.

☐ $10,000 ☐ $25,000 ☐ $50,000

11. RATING AND CLASSIFICATION INFORMATION

A. What is your present specialty? _____

B. What is your present sub-specialty? _____

C. What percentage of your practice is devoted to your specialty? _____% Sub-specialty _____ %

D. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years? ..... YES ☐ NO ☐

If "yes," describe the nature of changes in specialty or practice activities _____

E. Do you anticipate any changes in your specialty or practice activities (including the addition of new procedures) in the next year? ..... YES ☐ NO ☐

If "yes," describe the anticipated changes in specialty or practice activities _____

F. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty? ..... YES ☐ NO ☐

If "yes," please give complete details _____

G. Indicate the average number of: Patients seen per week: _____ Hours practiced per week: _____

H. How many hours per week are you on call? _____

I. If applying for obstetrical coverage, indicate

i. Average number of deliveries per year _____

ii. Percentage of high-risk deliveries _____

iii. Average number of VBAC deliveries _____

iv. What induction agents do you use on VBAC patients? _____

v. Do you have privileges to perform C-sections at each hospital you staff? ..... YES ☐ NO ☐

J. Do you practice Bariatric medicine? ..... YES ☐ NO ☐

i. If "yes," what drugs do you utilize for weight loss? _____

ii. Do you perform Bariatric surgery? ..... YES ☐ NO ☐

iii. If "yes," what percentage of your practice does such surgery constitute? _____

K. Do you now or have you ever provided services to any state, local or federal correctional facility, jail or prison? ..... YES ☐ NO ☐

If "yes," please explain: _____

L. Do you treat patients in a nursing home or similar facility? ..... YES ☐ NO ☐

If "yes," how many patients do you treat there per month, on average? _____

M. Do you serve as a medical director of a hospital, nursing home, or other facility? ..... YES ☐ NO ☐

If "yes," please provide details: _____

N. Do you or will you staff an emergency room? ..... YES ☐ NO ☐

i. If "yes," how many hours per week? _____

ii. If "yes," in what facilities or for what staffing company? _____

iii. Is this emergency room practice required for staff privileges? ..... YES ☐ NO ☐

O. Do you render care or perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as a medium for rendering medical services (telemedicine or internet medicine)? ..... YES ☐ NO ☐

i. If "yes," indicate all states where you see patients or where the patients being treated reside: _____

ii. What percentage of your total practice does this extra-state activity constitute? _____

P. Do you read or interpret films, slides or specimens of patients who reside in states other than your indicated state of practice? ..... YES ☐ NO ☐

If "yes," please explain and indicate all states in which the patients reside. Indicate the percentage of your practice corresponding to each such state: _____

_____

Q. Will you read your own x-rays? ..... YES ☐ NO ☐

i. If "yes," will they subsequently be read by a radiologist? ..... YES ☐ NO ☐

ii. If "yes," within how many hours? _____

R. Do you perform <u>hospital</u> surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? ..... YES ☐ NO ☐

If "yes," explain the type and volume of such surgeries and the average number of cases per month. _____

S. Do you perform surgical procedures at a same day surgery center other than your office? YES ☐ NO ☐

i. If "yes," what facility? _____

ii. How many procedures do you perform there annually? _____

T. Do you perform surgery in your office or private suite using anesthesia other than local? ... YES ☐ NO ☐

If "yes," you must complete the Office Anesthesia Supplemental Questionnaire.

U. Are you a sports team physician for any college, university, semi-professional or professional team? ..... YES ☐ NO ☐

If "yes," please explain. _____

V. Do you practice any of the following forms of "Alternative Medicine"?

Ayurvedic Medicine	YES ☐	NO ☐	Chiropractic Medicine	YES ☐	NO ☐
Chinese Medicine	YES ☐	NO ☐	Holistic Medicine	YES ☐	NO ☐
Homeopathic Medicine	YES ☐	NO ☐	Naturopathic Medicine	YES ☐	NO ☐

If you answered "yes" to any of the above, please describe your practice. _____

_____

W. Are you employed full time or part time by the federal, state or local government or are you on active military duty? ..... YES ☐ NO ☐

If "yes," please explain the nature of your employment and why you desire coverage. _____

_____

X. Do you or does any partnership or corporation of which you are a member or shareholder own or operate a surgery center, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice? ..... YES ☐ NO ☐

If "yes," please provide complete details on page 15. _____

If "yes," is access limited to members of your practice? ..... YES ☐ NO ☐

Y. Have you entered into any contracts with managed care organizations providing for capitated payments to you for patient care?..... YES ☐ NO ☐

If "yes," what percentage of your patients falls under such agreements? _____

Z. Are you ACLS or ATLS certified?..... YES ☐ NO ☐

Please check any of the following that apply to your practice. If none apply, so indicate.

- ☐ Abortion, elective
- ☐ Acupuncture
- ☐ Anesthesia
  - ☐ Caudal
  - ☐ Local
  - ☐ Spinal
  - ☐ Other _____
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On own patients
  - ☐ On patients of others
- ☐ Bariatric procedures
  - ☐ Gastric banding
  - ☐ Gastric bubble
  - ☐ Gastric bypass
  - ☐ Gastric stapling
- ☐ Blepharoplasty
  - ☐ Cosmetic
  - ☐ Reconstructive
- ☐ Breast Biopsy
- ☐ Breast Implants
- ☐ Breast Reduction
- ☐ Cardiac surgery
- ☐ Cataract surgery
- ☐ Chelation therapy
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Circumcision
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Cryosurgery, other than external lesions
- ☐ Dermatological procedures
  - ☐ Botox injection
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen injection
  - ☐ Dermabrasion
  - ☐ Fat transfer
  - ☐ Hair transplant
  - ☐ Laser hair removal
  - ☐ Laser skin resurfacing
  - ☐ Microdermabrasion
  - ☐ Silicone injection
  - ☐ Other _____
- ☐ D & C
- ☐ Dermatopathology
- ☐ Echocardiography
- ☐ Endoscopic laser therapy
- ☐ Endoscopy
  - ☐ Cystoscopy
  - ☐ Bronchoscopy
  - ☐ EGD
  - ☐ Gastroscopy
  - ☐ Hysteroscopy
  - ☐ Proctoscopy
  - ☐ Sigmoidoscopy
  - ☐ Other _____
- ☐ ERCP/ERC
- ☐ Exchange transfusion
- ☐ Facial plastic surgery
  - ☐ Elective cosmetic
  - ☐ Reconstructive
- ☐ Fluoroscopy
- ☐ Fracture Reduction
  - ☐ Closed
  - ☐ Open
- ☐ Hand surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip nailing
- ☐ Hyperbaric medicine
- ☐ Hysterectomy
- ☐ Intensive care for newborns
- ☐ Intensive care medicine for adults
- ☐ Infertility treatment
  - ☐ Medical
  - ☐ In vitro fertilization
  - ☐ Other surgical
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ LASIK
- ☐ Left heart catheterization
- ☐ Liposuction
  - ☐ Tumescent
  - ☐ Other
- ☐ Lithotripsy
- ☐ Mammography
- ☐ Mesotherapy
- ☐ Myelography
- ☐ Myomectomy
- ☐ Neonatology
- ☐ Organ transplantation
- ☐ Orthopedic surgery
  - ☐ Including spinal surgery
  - ☐ Without spinal surgery
- ☐ Osteopathic manipulative medicine
- ☐ Pain management
  - ☐ Cordotomy
  - ☐ Dorsal root gangliotomy
  - ☐ Facet blocks
  - ☐ Medication only
  - ☐ Nerve root blocks
  - ☐ Pump implantation and removal
  - ☐ Rhizotomy
  - ☐ Sphenopalatine lesioning
  - ☐ Spinal injections
  - ☐ Thoracic sympathectomy
  - ☐ Trigeminal lesioning
  - ☐ Other _____
- ☐ Percutaneous vertebroplasty
- ☐ Pacemaker placement
- ☐ Polypectomy
- ☐ Prenatal care
- ☐ Prolotherapy
- ☐ Provertin retinal therapy
- ☐ Radiation therapy
- ☐ Radiopaque dye injection
- ☐ Roux-en-Y
- ☐ Sclerotherapy
- ☐ Spinal fusion
- ☐ Spinal surgery, other
- ☐ Thoracic surgery _____%
- ☐ Thyroidectomy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery/hormonal gender conversion
- ☐ Tubal ligation
- ☐ Vascular surgery _____%
- ☐ Vasectomy

☐ **None of the above apply to my practice (Initial)_____**

☐ **Other procedures not listed above (Please list)**

_____
_____
_____
_____

IMPORTANT – YOU MUST READ CAREFULLY

GENERAL FRAUD WARNING

Any person who knowingly includes any false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.

Arkansas: 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 fines and confinement in prison.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

Florida: 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: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana: 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 fines and confinement in prison.

Maine: 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 denial of insurance benefits.

Missouri: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

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

New Mexico: 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 fines civil and criminal penalties.

New York: 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.

Ohio: Any person who, with intent to defraud or knowing that he 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.

Oklahoma: 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.

Pennsylvania: 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.

Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

West Virginia: 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 fines and confinement in prison.

Consent, Warranty, Representations and Acknowledgement of Understanding

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance that may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and is not evidence of coverage.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant and that my application will be evaluated by authorized personnel. Submission of a payment or a deposit with this application and provisional receipt thereof by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment will be returned to the applicant. I further acknowledge that incomplete or incorrect information could result in

retroactive premium adjustment, denial of coverage or voidance of any policy issued in reliance on such information.

Applicant's Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by PROASSURANCE SPECIALTY INSURANCE COMPANY, INC OR PROASSURANCE CASUALTY COMPANY (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all professional associations and societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, any Board of Professional Examiners or Licensure Commission for any state in which he has practiced or resided, and any and all physicians, dentists or any other third party having information regarding the undersigned, to release to the Company upon its request any information that any such person or entity may have which in the judgment of such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

_____

Date: _____

ADDITIONAL COMMENTS

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each. Attach additional sheets if needed for adequate explanation. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____
2. Date reported to insurance company: _____
3. Name of Insurance Company: _____
4. Date of incident and your treatment: _____
5. Allegations: _____

   _____

   _____
6. What is the present condition of the patient? _____

   _____
7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... YES ☐ NO ☐
8. Status of claim (check applicable answer):

☐Suit threatened, no action taken ☐Suit filed but dropped by claimant ☐Summary judgment in your favor ☐Suit settled out of court a. Date claim paid: _____ b. Amount paid: $ _____ c. Did you want to settle this claim? ☐YES ☐NO	Court outcome in your favor: ☐Jury verdict ☐Directed verdict Court outcome in favor of plaintiff: ☐Jury verdict ☐Directed verdict Amt. of loss payment: $ _____	Unresolved/Open Claim: ☐Awaiting mediation ☐Awaiting court action Reserve Amount: $_____

9. Name and address of the attorney assigned to your case: _____

   _____
10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ..... YES ☐ NO ☐

    If "yes", amount was $ _____
11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____

    _____

    _____

    _____

Signature: _____ Date: _____

Name (Printed): _____