This is an Application for Claims-made Coverage – Please Read Carefully

Physicians And Surgeons Professional Liability Application

I. GENERAL INFORMATION (if additional space is needed, please attach a separate sheet of paper.)

1. If my application is approved, my requested coverage date is ______________________ at 12:01am

2. ______________________ , ☐ MD ☐ DO ______________________
First Name   Middle Name   Last Name   Check One   Social Security Number

3. ____ /____ /_____   ______________________   4. ______________________
Date of Birth   Place of Birth   Driver's License Number and State of Issue

5. List practice locations including all offices, nursing homes, urgent care clinics and all other non-hospital locations *(list principal location first)*:

a. ______________________
Number & Street   Suite   City   State   Zip   County   % of Practice   Type of Location

____
Business Phone Number   Fax Number   E-mail Address   Website Address

b. ______________________
Number & Street   Suite   City   State   Zip   County   % of Practice   Type of Location

c. ______________________
Number & Street   Suite   City   State   Zip   County   % of Practice   Type of Location

6. ______________________
Home Address   City   State   Zip   County   Home Phone

7. Desired mailing address: ☐ Home ☐ Office ☐ Other ______________________

Furnish billing address if different from mailing address:

____
Number & Street   Suite   City   State   Zip   County

8. State(s) in which you hold a license to practice medicine:

______________________   ______________________
State   License Number   Status   State   License Number   Status

______________________   ______________________
State   License Number   Status   State   License Number   Status

PRIOR ACTS COVERAGE:

9. **If you switch to MagMutual, do you want us to also cover your medical acts for the period you were insured with your present carrier (Prior Acts Coverage)?** ☐ **Yes** ☐ **No**

If "Yes", please complete a supplemental application for physicians requesting coverage for acts occurring prior to the effective date of this policy. If "No", will you purchase an extended reporting endorsement (tail coverage) that provides coverage for the acts occurring prior to the effective date of this policy from your current carrier? ☐ **Yes** ☐ **No**

II. EDUCATIONAL BACKGROUND

1. ____

Medical School | State | Country | Year Graduated

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates?
☐ Yes ☐ No ☐ Not applicable

Have you passed the FLEX? ☐ Yes ☐ No When ______☐ Not applicable
Have you passed the USMLE? ☐ Yes ☐ No When ______☐ Not applicable

2. Names, locations and dates of internships and/or residencies served:

Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
Institution	Location	Special Program	Mo./Yr. to Mo./Yr.

a. Did you successfully complete your residency training? ☐ Yes ☐ No

If not, explain why: ____

b. Explain any additional years spent in a residency program: ____

c. Explain any gaps in time from date of medical school graduation to completion of residency:____

____

3. Additional training (fellowship, etc.):

Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
Institution	Location	Special Program	Mo./Yr. to Mo./Yr.

4. Are you currently a resident, intern or fellow: ☐ Yes ☐ No If “Yes”, date you will complete training: ____________________

5. a. Are you certified by an approved specialty board? ☐ Yes ☐ No

Certifying Board	Cert.	Elig.	Date Certified	*Date Eligibility Expires
____________________	☐	☐	____________________	____________________

*If eligible for over five years but not certified, please explain:____

____

b. Have you ever failed a Board exam? ☐ Yes ☐ No If “Yes”, which Board exam and how many times on each part? ____ oral _____ written

____

III. PHYSICIAN UNDERWRITING INFORMATION

It is necessary that this section be completed by the physician applicant.

1. ____

Name of current professional liability insurance company (enclose copy of Introduction Page or Declaration Page) / # of years with carrier / current premium)

2. What is the date that your current policy will expire?____

3. If your answer to any of the following is "Yes," give details on a separate signed and dated sheet of paper. **If your answer to "e" and/or "f" is "Yes" it is also necessary to complete the Underwriting Claim Investigation form for each claim.**

a. Has your license to practice medicine in any state or country or your permit to prescribe drugs ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation? ☐ Yes ☐ No

b. Have you ever been or are you currently under a Consent Order or agreement with any state licensing board of medical examiners, DEA, or governmental agency (public or private)? If "Yes", attach a copy of the applicable documents. ☐ Yes ☐ No

c. Have your hospital staff or other healthcare facility privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered, subject to involuntary monitoring, in any other way restricted, or have they been or are they currently under investigation? ☐ Yes ☐ No

d. Has any insurance company (including Lloyd's of London) ever canceled, declined to issue or refused to renew your medical professional liability insurance, or offered such insurance only on special terms, such as an involuntary deductible or surcharge, or have you been notified of such intent? (Enclose copy of Cancellation Notice or Letter if applicable.) ☐ Yes ☐ No

e. Has any civil action or claim ever been filed against you or have you been notified that any civil action or claim will be filed against you alleging medical errors or omissions? ☐ Yes ☐ No

f. Have any judgments been made against you, or any out-of-court settlements been made on your behalf or as a result of your alleged act or omission from an incident alleging medical negligence, errors or omissions? ☐ Yes ☐ No

g. Have you ever been convicted of a criminal offense, pled guilty to a criminal offense or are you under investigation for a criminal offense? ☐ Yes ☐ No

h. Have you been treated or evaluated for alcoholism, narcotics or other substance abuse, sexual addiction/misconduct, anger management issues or any other mental illness? (Provide dates and locations of all treatments or evaluations, and the names of your supervising and monitoring physicians.) ☐ Yes ☐ No

i. Are you currently treating or do you intend to treat any patient by means of an experimental, investigative, unconventional or "off-label" drug or therapy? ☐ Yes ☐ No

j. Has your involvement in any health program (e.g. Medicare, Medicaid, HMOs, PPOs, or other managed care provider) ever been suspended, placed on probation, terminated, or limited in any way? ☐ Yes ☐ No

4. a. Check (✓) type of practice for which you are applying:

☐ Solo Physician	☐ Partnership (include name)	☐ Professional Association
☐ Solo Medical Corporation	☐ Use of assumed name (DBA)	☐ Locum Tenens (substitute or temporary physician)
☐ Professional Corporation	☐ Group Member (include name)	☐ Employed Physician (include name of employer)
☐ Independent Contractor	☐ Resident/Fellow-Program	

If you checked any boxes above other than "Solo Physician", list below the name of Applicable entity(ies) and/or any physician(s).

NAME(S) ENTITY(IES)	NAME(S) OF EMPLOYER(S)	PROFESSIONAL LIABILITY INSURANCE CARRIER(S)	EMPLOYMENT/CONTRACT DATE (MM/DD/YY) TO (MM/DD/YY)

b. Are you applying for coverage for any of the above entities? ☐ Yes ☐ No If "Yes", which one(s): ______________________________
Please submit a copy of the Corporate Charter. (Verification of the legal name and ownership.)

Other Physicians: Do you practice with other physicians not listed above? ☐ Yes ☐ No
If "Yes", list the physician(s) with whom you practice and describe the association.

Physician(s)	Association

c. Are you requesting that we: (check one) ☐ Add you to a current MagMutual policy? (Policy No.: ____________________); or ☐ Issue you a solo policy?

5. a. ______________________ ______________________
Your Primary Medical Specialty Your Sub-specialty (if applicable)

b. Is your practice limited to your specialty and/or subspecialty? ☐ Yes ☐ No

c. Do you perform any procedures not routinely performed by physicians in your specialty or sub-specialty? ☐ Yes ☐ No
If "Yes", please explain ______________________

6. Describe your intended medical practice for which you are applying: ______________________

a. Have your practice specialties and/or procedures changed in the past 5 years? ☐ Yes ☐ No

b. Are you planning any changes to the nature and/or extent of your practice within the next 12 months? ☐ Yes ☐ No

c. Are you planning to add any additional procedures to your practice within the next 12 months? ☐ Yes ☐ No
If "Yes" to either, please explain ______________________

7. a. Locations and dates of practice (account for all time including military and faculty):
(Attach a copy of your most recent curriculum vitae.)

Dates	Location	Dates	Location

b. Explain any gaps in employment history and any period(s) that you were uninsured: ______________________

____

8. Are you part-time ☐ Yes ☐ No If "Yes", and you are requesting Prior Acts Coverage, enclose a copy of proof that you are currently eligible for a part-time discount with your current carrier. **Additionally, please request a part-time application.**

9. a. Are you engaged in any "moonlighting" activities? ☐ Yes ☐ No
If "Yes", number of hours per month: __________ Organization: ______________________

Please describe such activities: ______________________

Will you maintain professional liability insurance with other insurance companies for moonlighting activities? ☐ Yes ☐ No
If "Yes", name of insurance carrier (enclose copy of Declaration Page): ______________________

b. Are you providing any other medical services for which you do not need coverage with us? ☐ Yes ☐ No
If so, what type of services and who is insuring them? ______________________

10. a. List all hospitals and surgical centers where you currently have staff privileges or have applied for staff privileges and % of practice at each:

Name	**City/State**	**Applied**	**Active**	**Courtesy**	**% of practice**

b. Do you provide any call coverage for physicians outside of your practice specialty? ☐ Yes ☐ No
If "Yes", please explain: ______________________

____

c. If you do not have admitting privileges, please describe in detail your procedure for handling your patients who may require in- patient care: ______________________

11. **Do you perform any of the following procedures?** ☐ **Yes** ☐ **No** **If "Yes", check (✓) all procedures you perform and enter the appropriate number you perform each month where indicated:**

- ☐ Abdominal surgery _______ per mo.
- ☐ Abortions _______ per mo.
- ☐ Where: ______________________________
- ☐ Trimester______________________________
- ☐ Acupuncture _______ per mo.
- ☐ Adenoidectomies _______ per mo.
- ☐ Amniocentesis
- ☐ Angiography
- ☐ Venous
- ☐ Arterial
- ☐ Peripheral angioplasty
- ☐ Appendectomies _______ per mo.
- ☐ Assistance in major surgery
- ☐ On own or group's patients only
- ☐ On patients of others
- ☐ Back/spinal surgery _______ per mo.
- ☐ Bariatric surgery _______ per mo.
  - ☐ Cosmetic
- ☐ Medical necessity
- ☐ Cardiac catheterization
- ☐ Diagnostic coronary angiography
- ☐ Left heart catheterization
- ☐ Permanent pacemaker
- ☐ PTCA (coronary angioplasty)
- ☐ Cardiac surgery _______ per mo.
- ☐ Cholecystectomies _______ per mo.
- ☐ Circumcisions (other than newborn)
- ☐ Colonoscopies/sigmoidoscopies
- ☐ Cryosurgery on malignant lesions
- ☐ Cosmetic surgery (elective) ______ per mo.
  Detail each type and number per type
  ____
  ____
- ☐ CT scanning __ no dye __ with dye
- ☐ C-sections _______ per mo.
- ☐ Deliveries _______ per mo.
- ☐ Dilation and curettage _______ per mo.
- ☐ Diskography
- ☐ EGD
- ☐ Endoscopies _______ per mo.
- ☐ List of endoscopies performed
  ____
  ____
- ☐ ERCP
- ☐ Flexible sigmoidoscopies
- ☐ Fluoroscopic procedures
- ☐ Hemorrhoidectomies
- ☐ Herniorrhaphies _______ per mo.
- ☐ Hysterectomies _______ per mo.
- ☐ Image guided Biopsy _______ per mo.
- ☐ Injection of irradiated substances into the blood stream for diagnostic purposes (IVPs)
- ☐ Laminectomies _______ per mo.
- ☐ Large Core Needle Biopsy
- ☐ Liposuction _______ per mo.
  type ______________________________
  area(s) of body ______________________
- ☐ Lumbar puncture
- ☐ Lymphangiography
- ☐ Mammography _______ per mo.
- ☐ Myelography
- ☐ Neo-natal intensive care visits
- ☐ Phlebography
- ☐ Open reductions _______ per mo.
- ☐ Orthopedic surgery _______ per mo.
- ☐ Pneumatic or mechanical esophageal dilation
- ☐ With Bougie or olive clip
  - ☐ Without Bougie or olive clip
- ☐ Pneumoencephalography
- ☐ Pre-natal care past first trimester
- ☐ Radiation therapy
- ☐ Radiopaque dye injection (other than IVP) in the blood vessels, lymphatics, sinus tracts and fistulae
- ☐ Shock therapy (ECT/EST)
- ☐ Thoracic surgery _______ per mo.
- ☐ Tonsillectomies _______ per mo.
- ☐ Trauma surgery _______ per mo.
- ☐ Tumor Ablation
- ☐ Vascular surgery _______ per mo.
- ☐ Vasectomies
- ☐ Vertebroplasty _______ per mo.
- ☐ Other surgeries/no. _______ per mo.
  ____
  ____
- ☐ Administer or supervise anesthesia (If so, complete question 16)
- ☐ Other ______________________________
  ____
  ____
  ____
  ____
  ____
  ____
  ____
  ____

12. Do you maintain a surgical suite(s) at any of the practice locations listed on page 1, question number 5 or at any other location?

    ☐ Yes ☐ No If "Yes", explain: ____

    a. Do you maintain a full emergency cart? ☐ Yes ☐ No

    i) Do you follow a protocol for checking a cart on a regular basis? ☐ Yes ☐ No

    ii) Are the checks documented? ☐ Yes ☐ No

    b. Is other than local anesthesia in the surgical suite administered? ☐ Yes ☐ No

    If "Yes", type(s) used: ____

    i) Who administers the anesthesia? ____

    c. Does anyone other than you or members of your organization use this facility? ☐ Yes ☐ No

13. Do you own (☐ Yes ☐ No) or use (☐ Yes ☐ No) surgical center facilities?

    If "Yes", name & location of facility: ____

14. Are the facilities noted in #12 and #13 accredited by the Accreditation Association for Ambulatory Healthcare or any similar organization? ☐ Yes ☐ No

15. a. Do you normally staff an emergency room other than on rotational call? ☐ Yes ☐ No

If "Yes", how often? ______________________________

b. Do you normally take on-call rotation in the ER? ☐ Yes ☐ No

When on call, frequency of rotation and average hours in the ER per month: ______________________________

Are you certified? ☐ ACLS ___________ Exp. date ☐ ATLS ___________ Exp. date ☐ PALS ___________ Exp. date

16. TO BE COMPLETED IF YOU ADMINISTER ANY ANESTHESIA OR SUPERVISE ADMINISTRATION OF ANY ANESTHESIA (IF NOT CONTINUE TO NO. 17):

Do you perform pain management only? ☐ Yes ☐ No

Do you administer anesthesia only as an anesthesiologist? ☐ Yes ☐ No

Do you supervise an anesthesiology department? ☐ Yes ☐ No

What is the maximum number of anesthetic assistants you supervise at any one time? ________

Are you always present during intubation and initial dosing by anesthetic assistants? ☐ Yes ☐ No ☐ N/A

Are you ever off premises while supervising anesthetic assistants? ☐ Yes ☐ No ☐ N/A

Are the anesthetic assistants you supervise hospital/facility employees? ☐ Yes ☐ No ☐ N/A

If "Yes", are they also supervised by a physician anesthesiologist if you are a surgeon? ☐ Yes ☐ No ☐ N/A

If not hospital/facility employees, who is the employer? ______________________________

Do you administer any anesthesia as a surgeon? ☐ Yes ☐ No

Do you work with, or have you ever worked with, a chiropractor who performs manipulation under anesthesia? ☐ Yes ☐ No

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

17. Do you perform chelation therapy? If so, for what reasons? ______________________________

18. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunication, video, or information systems? If so, please describe:

19. Do you provide medical professional services to correctional institution inmates (i.e. federal or state prisons, county jails, or youth detention centers)? ☐ Yes ☐ No Number of hours per month? ________

20. Does your practice involve weight reduction or control, other than prescribing exercise? ☐ Yes ☐ No
(Percentage of patients exclusively for weight reduction or control ________%)
If "Yes", please explain fully including name of medication(s) prescribed or dispensed or surgery performed:

____

21. Do you supervise residents? If "Yes", please explain below. ☐ Yes ☐ No

____

22. Do you provide medical professional services to any members of a professional or collegiate sports team or organization? ☐ Yes ☐ No

a. If "Yes", which professional team(s)/organization(s) do you provide these services to?

____

b. If "Yes", what is your title or role with the team(s)/organization(s) (volunteer, team physician, etc.?)

____

23. Do you perform or provide supervision for others performing any cosmetic aesthetic procedures? ☐ Yes ☐ No
Please indicate the procedure, location and whether personally performed. (Please submit certificates of training if applicable).

____

____

24. Do you provide medical services at any Nursing Home? If "yes", please explain ________________________ ☐ Yes ☐ No

____

25. Do you have any Medical Director responsibilities? If "Yes", please list name, type and location of entity. ☐ Yes ☐ No

____

26. Are you a member of the Neurological Injury Compensation Association (NICA) (Florida only) or a member of Virginia Neurological Birth Injury Fund (Virginia only)? ☐ Yes ☐ No

27. Do you perform medical Utilization Review Management evaluations for health care organizations? ☐ Yes ☐ No

If "Yes", please explain: ____

28. **LIMITS OF COVERAGE REQUESTED**: Check the appropriate blank.

☐ $250,000 Each loss/$750,000 Annual Aggregate limit (Available in Florida only)

☐ $500,000 Each loss/$1,500,000 Annual Aggregate limit (Available in Florida only)

☐ $1,000,000 Each loss/$1,000,000 Annual Aggregate limit

☐ $1,000,000 Each loss/$3,000,000 Annual Aggregate limit

☐ $2,000,000 Each loss/$4,000,000 Annual Aggregate limit (Not available in Florida)

☐ $2,050,000 Each loss/$6,150,000 Annual Aggregate limit (or the full limit as capped by Virginia Code Section 8.01-581.15) (Virginia only)

☐ $3,000,000 Each loss/$5,000,000 Annual Aggregate limit (Not available in Florida)

PLEASE ENCLOSE A COPY OF THE RENEWAL CERTIFICATE/DECLARATIONS PAGE FROM YOUR PRESENT POLICY WHICH SHOWS YOUR RETROACTIVE DATE. ATTACH YOUR CURRICULUM VITAE.

(ATTACH SEPARATE SHEET FOR ADDITIONAL ANSWERS OR EXPLANATIONS.)

IV. EMPLOYEE INFORMATION

1. Do you employ and/or provide supervision for any of the following allied healthcare professionals listed below? ☐ Yes ☐ No
   If "Yes", please include name of each, license number of each, date employed, and insurer of each.

	Name	License #	Date Employed	Insurer
Anesthetic Asst. (CRNA, PA or AA)				
Nurse Midwife (CNM)				
Nurse Practitioner (NP)/ Physician's Asst. (PA)				

2. Do you want to provide coverage for any of the above listed employees with the policy that may be issued from this Application? ☐ Yes ☐ No
   If "Yes":
   a. Do you want a separate limit for them? If so, please provide copy of their current Declarations Page and date of birth. ☐ Yes ☐ No
      Are they full or part-time employees? ☐ Full-Time ☐ Part-Time Explain: ______

   OR: ☐ My Limits

   b. Do you want them to share in your limits or the limits of the organization (if organization has separate limit)? ☐ Organizational limit

3. Do you supervise any non-employed allied healthcare professionals other than those already listed above? ☐ Yes ☐ No If yes, please explain:

   ______

4. Has any claim or lawsuit ever been brought against any of the employees listed above? ☐ Yes ☐ No

5. Do you have a signed protocol agreement in place for any of the individuals referenced above? ☐ Yes ☐ No

V. BUSINESS INFORMATION

It is necessary to complete this section for solo incorporated physicians and **group entities** (groups should only complete one Business Information section).

1. ______ ______ ______
   Organization name (legal name | Policy number (if currently insured with MagMutual or Professional Security Ins. Co.) | Date organization was formed

2. Chief Executive Officer: ______

3. Check only one: ☐ Yes ☐ No Do you want your organization to share in the physician's individual limit? (a shared limit of coverage requires no additional charge) - or - ☐ Yes ☐ No Do you want a separate limit of coverage provided to the organization? (a separate limit of coverage requires an additional charge and requires underwriting approval)

4. Organizational structure information:
   a. Is the organization 100% physician owned? ☐ Yes ☐ No
      If "No", please explain: ______

   b. Is the organization owned by an allied healthcare professional that you supervise? If so, who? ☐ Yes ☐ No

      ______

   c. Does the group combine revenues, expenses and share in profits? ☐ Yes ☐ Noo
   d. Does the group have a centralized patient records, billing and collection system? ☐ Yes ☐ No
   e. Are all group members practicing at the principal office address? ☐ Yes ☐ No
   f. Are any physician members employed by other organizations? ☐ Yes ☐ No
      If "Yes" to "f" , please explain: ______

5. List names of all other entities to be insured, such as professional organizations of insured physicians and subsidiaries of the principal organization. Indicate if each is a corporation, partnership, joint venture, etc. (Include date of formation and where it is incorporated):

____

____

6. List all physicians affiliated with the organization(s) and the current insurer of each. (Use separate sheet of paper if necessary).

Name	Insurer	Name	Insurer
Name	Insurer	Name	Insurer

7. Have there been any settlements/judgments made on behalf of the organization, or are any lawsuits or claims pending? ☐ Yes ☐ No
If "Yes", please complete Underwriting Claim Investigation form.

8. Other products and services available through MagMutual (please check (√) those you would like more information on):

☐ Workers' Compensation Insurance
☐ Businessowners Insurance
☐ Employment Practices Liability Insurance
☐ Regulatory Fraud and Abuse Insurance and Consulting
☐ Healthcare Services Facility Insurance
☐ Auto, Home and Personal Liability Insurance
☐ Personal or Group Health Insurance
☐ Pension Planning, Establishing or Managing Your IRA
☐ Disability Income Protection, Life Insurance
☐ Financial and/or Estate Planning

May we send information about our products and services to your e-mail address? ☐ Yes ☐ No

9. How did you hear about MagMutual?______________________________

IMPORTANT – FOR YOUR OWN PROTECTION – Report immediately, and in writing, to your current insurer all incidents which might lead to a claim against you. This includes: requests for records, depositions, notices, subpoenas, complaints of patients or patients' families who threaten to bring legal action, or any other incident which might give rise to a claim from an unfavorable result in treatment.

No Prior Acts Coverage

IMPORTANT: If you have previously been insured under a claims-made policy, please read.

A claims-made policy covers claims resulting from medical professional services provided or withheld on or after the retroactive date shown on the policy and first reported while the policy is in force. If you have been insured by a claims-made policy and did not purchase the Extended Reporting Endorsement from the insurer, you are NOT insured for your acts prior to the effective date of this policy. MagMutual has no obligation to defend or to pay claims resulting from medical professional services provided or withheld prior to the effective date of any policy issued upon this application.

PRIOR ACTS COVERAGE MAY BE AVAILABLE, BUT REQUIRES A SUPPLEMENTAL APPLICATION AND PREMIUM.*
[*See question number 9, page 1.]

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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states and may subject the person to criminal and civil penalties.

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. Fla. Stat. § 817.234(1)(b).

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. KRS § 304.47-030.

TENNESSEE AND 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. Tenn. Code Ann. § 56-53-111(b)(1)(A). Va. Code Ann. § 52-40 (B).

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. MD Bull. 08-23.

IT IS NECESSARY FOR ALL APPLICANTS TO SIGN SPACES BELOW.

IMPORTANT: Incomplete or incorrect information could result in a retroactive upward premium adjustment, or could lead to a denial of coverage in the event of a claim.

I hereby declare that the statements and responses I have provided in this application are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that deliberate misstatements, which are deemed material or fraudulent, may be grounds for cancellation or denial of coverage in the event of a claim.

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 and denial of insurance benefits.

I understand that this is an application for insurance and not an insurance binder. I also understand that, if my application is approved, my effective date cannot be prior to the date that I have met all of the Company's requirements for issuance.

X ______________________________ ______________________________

Applicant's Signature (required) Date

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance with the Company (MAG Mutual Insurance Company and Professional Security Insurance Company) hereby authorizes his/her 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 all non-privileged 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/her acceptability to the Company as a professional liability risk.

The undersigned also authorizes all medical associations, medical societies and managed care organizations in which he/she is or has been a member, all hospitals in which he/she now holds or has held staff privileges, the state board of medical examiners for the state in which he/she has practiced, the state department of public health for the state in which he/she has practiced or resided, motor vehicle departments, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which, in the judgment of any such person or entity, has a bearing upon his/her acceptability to the Company as a professional liability risk. The undersigned hereby agrees to hold harmless from and against any and all claims, demands and causes of action against any person or entity who releases information on his/her behalf according to this authorization. Furthermore, the undersigned agrees to hold harmless to the same extent the Company and any of its present or former employees and agents. **The undersigned acknowledges that this application may be used by the Company to underwrite coverage with MAG Mutual Insurance Company and/or Professional Security Insurance Company. Applications for Professional Security Insurance Company may be submitted only through a licensed, surplus lines broker or agent as Professional Security Insurance Company is an unauthorized insurer eligible to transact insurance in your state under applicable surplus lines insurance laws.**

X ______________________________

Applicant's Signature (required)

By signing in the space below, you also authorize the Company or its duly authorized agents to provide a CERTIFICATE OF INSURANCE to interested parties.

X ______________________________ ______________________________

Applicant's Signature (optional) Date

X ______________________________ ______________________________

Agent's Name Agent's License Number