

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
 2. Application must be signed and dated by owner, partner or officer.
 3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.
 4. Please do not complete application earlier than 45 days before proposed effective date of coverage.
 5. If you have a Curriculum Vitae (C.V.), please attach to application and check here ____.
- (PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full name of applicant (include professional degree) :

b. Principal Business Address:

Please attach list of additional locations.

c. Business Phone: (____) _____ Home Phone: (____) _____

d. Date of Birth: _____ Place of Birth: _____

e. Social Security No.:

f. Are you a U.S. citizen? [] Yes [] No. If no, please indicate your status and the date of entry into the U.S.

g. Limits of liability requested:

(i) \$ _____ each claim \$ _____ aggregate \$ _____ deductible

(ii) Effective Date (12:01 A.M.):

h. [] Solo practitioner (uninc.) [] Solo practitioner (inc.) [] Professional corporation [] Professional Association
 [] Partnership [] Employee of _____
 (Give Name of Employer)

i. If you practice other than as an employee OR an unincorporated solo practitioner ONLY:

(i) Please list the names of ALL your partners, your employees, or members of your professional association or corporation who practice medicine.

(ii) Formal corporate, association, partnership or business name.

(iii) Please attach a copy of your letterhead.

j. Please list the states in which you practice and provide your respective license numbers:

State

License Number

1. APPLICANT INFORMATION (CONTD).

k. Please list the hospitals where you are currently on staff and indicate the percentage of work at each hospital.

<u>Hospital</u>	<u>Percentage of Work</u>

l. Briefly describe the type and extent of your hospital privileges.

m. Are you "chief of" or the "head" of any hospital department? Yes No

n. Do you or the firm indicated in question 1(i) above own (either wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes No

If yes, please provide a detailed explanation specifically including the name, location, size, and number of beds.

2. APPLICANT EDUCATION

<p>a. Please provide the name and address of the medical school(s) that you attended indicating the degree(s) received and the year they were attained:</p>	<p>e. Are you American Board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate the medical specialty in which you are certified, your date of certification, and any recertification dates.</p>
	<p>f. Please provide a detailed summary of where you have practiced your profession since completing your training:</p>
<p>b. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please state the year of your certification and describe your medical degree.</p>	<p>g. Are you a member of any professional societies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide information regarding your membership(s).</p>
<p>c. Did you complete any residency programs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide a detailed explanation specifically including the type of residency program, the dates of each program, and the location and facility where they were served.</p>	<p>h. Have you participated in any continuing medical education program(s) within the past five (5) years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide a detailed explanation.</p>
<p>d. Have you received any additional medical training? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide an explanation specifically detailing the type of medical training, where the training was received, and the time period in which it was obtained.</p>	<p>i. Do you or the firm named in question 1(i) above own, operate, or provide professional services for any health care facility or business enterprise not already clearly described in this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach a detailed explanation.</p>

3. APPLICANT PRACTICE

a. What is your medical or surgical specialty:

b. Do you limit your practice to the above specialty? [] Yes [] No

c. Do you have a sub-specialty? [] Yes [] No

If yes, please provide a detailed explanation.

d. Do you perform one or more of the following procedures? Please check all that apply and provide a detailed explanation for all items checked including the name and location of the offices, hospitals, or centers where the procedures are performed.

- | | |
|--|---|
| <input type="checkbox"/> Endoscopic procedures (other than Sigmoidoscopy or proctoscopy) | <input type="checkbox"/> Chemabrasion |
| <input type="checkbox"/> Catheterization (other than swan-ganz, umbilical cord, urethral catheterization, or arterial line in a peripheral vessel) | <input type="checkbox"/> Dermabrasion |
| <input type="checkbox"/> Dilation and Curettage | <input type="checkbox"/> Hair transplants or suturing of hairpieces |
| <input type="checkbox"/> Needle biopsies | <input type="checkbox"/> Mohn micrographic surgery |
| <input type="checkbox"/> Electroshock therapy or hypnosis | <input type="checkbox"/> Acupuncture (for analgesia) or acupuncture anesthesia |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Prenatal care and normal deliveries |
| <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Home deliveries |
| <input type="checkbox"/> Myelography | <input type="checkbox"/> Supervise midwives |
| <input type="checkbox"/> Phenmoencephalography | <input type="checkbox"/> Radial keratotomy |
| <input type="checkbox"/> Interventional radiology | <input type="checkbox"/> Hexagonal keratotomy |
| <input type="checkbox"/> Percutaneous transluminal angioplasty or embolization | <input type="checkbox"/> Any minimal incision surgery |
| <input type="checkbox"/> Radiation therapy (including radium transplants) | <input type="checkbox"/> Surgery (other than incision of boils and superficial abscess or suturing skin and superficial fascia) |
| <input type="checkbox"/> Cosmetic plastic surgery (cosmetic body contouring implantations, injections and/or blepharopigmentation) | <input type="checkbox"/> Non-spontaneous abortions(1st or 2nd trimester) |
| <input type="checkbox"/> Open reduction of fractures | <input type="checkbox"/> Sterilization procedures |
| <input type="checkbox"/> Hysterectomies | <input type="checkbox"/> Spinal surgery (including chemonucleolysis and/or percutaneous lumbar discectomy) |
| <input type="checkbox"/> Laparoscopic hysterectomies | <input type="checkbox"/> Administer anesthesia (general spinal or caudal block) |
| <input type="checkbox"/> Tonsillectomies | <input type="checkbox"/> Cholecystectomies |
| <input type="checkbox"/> Adenoidectomies | <input type="checkbox"/> Laparoscopic cholecystectomies |
| <input type="checkbox"/> Weight reduction surgery | <input type="checkbox"/> Caesarian sections |
| <input type="checkbox"/> Experimental research, surgical research, or experimental therapy in human patients | <input type="checkbox"/> Organ Transplantations |
| <input type="checkbox"/> Sex change operations | <input type="checkbox"/> Other surgery _____ |

e. Do you perform surgery in your office? [] Yes [] No

If yes, please describe the surgical procedure.

g. Is general anesthesia administered for any of the surgeries performed in questions 3(e) and 3(f)? [] Yes [] No

If yes, please indicate whether the anesthesia is administered by you or by an anesthesiologist.

f. Do you perform surgery in non-hospital facilities? [] Yes [] No

If yes, please indicate the facility and describe the surgical procedure.

h. Do you assist in surgery either on your own patients or on the patients of others? [] Yes [] No

<p>i. Do you perform any hospital emergency room care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide a detailed explanation specifically indicating the approximate hours per month spent in emergency room care, whether it is a requirement for staff privileges, and whether this care is for only your own patients.</p>	<p>n. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hour walk-in clinic or birthing center? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide a detailed explanation including the location of the center.</p>
<p>j. Does your practice include plastic surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what percentage of the practice is devoted to traumatic surgery and cosmetic surgery.</p>	<p>o. What is your average patient load?</p> <p>Please provide information for number of patients weekly and number of patients annually.</p>
<p>k. Does your practice include weight reduction or control (other than by diet-exercise)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide a detailed explanation including the percentage of patients that are specifically weight control patients, whether you dispense any drugs and the names of the drugs, and whether you use injections for weight control and a list of the drugs injected.</p>	<p>p. What is the average number of hours devoted to your practice each week:</p>
<p>l. Does your practice include weight reduction or control (other than by diet-exercise)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide a detailed explanation including the percentage of patients that are specifically weight control patients, whether you dispense any drugs and the names of the drugs, and whether you use injections for weight control and a list of the drugs injected.</p>	<p>q. Do you anticipate any changes in your practice within the next year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please explain.</p>
<p>m. (i) Please list the number and type of professional employees in your practice. If NONE, state none.</p> <p> <input type="checkbox"/> Physicians (other than yourself) <input type="checkbox"/> Surgeon's assistants* <input type="checkbox"/> Nurse practitioners* <input type="checkbox"/> Physician's assistants* <input type="checkbox"/> Nurse anesthetists <input type="checkbox"/> Other _____ </p> <p>*Describe duties in detail, including extent supervised, on separate sheet.</p> <p>(ii) Are all of the above individuals licensed in accordance with applicable state and federal regulations? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please attach a detailed explanation.</p>	<p>r. What is the approximate gross annual income from your practice? (Please check one).</p> <p> <input type="checkbox"/> less that \$50,000 <input type="checkbox"/> \$ 50,000 to \$ 99,999 <input type="checkbox"/> \$100,000 to \$199,999 <input type="checkbox"/> \$150,000 to \$199,999 <input type="checkbox"/> \$200,000 or more (please estimate) <input type="checkbox"/> Other _____ </p>

s. Please list prior professional liability insurance carried for each of the past five (5) years. If NONE, state none.

Insurance Company	Limits of Liability	Premium	Inception Mo/Day/Yr.	Expiration Mo/Day/Yr.	Was this a Claims Made Policy Form?		Retro Date
					<u>Yes</u>	<u>No</u>	

Please attach a copy of the declarations page from your most recent coverage.

t. Do you supervise any individuals other than your own employees? [] Yes [] No
 If yes, please provide a detailed explanation of their responsibilities and the relationship to the entity which employs these individuals.

u. Please indicate by profession the number of individuals supervised.

<u>Number</u>	<u>Type of Profession</u>	<u>Number</u>	<u>Type of Profession</u>
_____	Physicians	_____	X-ray Technicians
_____	Laboratory Technicians	_____	Other _____

4. APPLICANT AFFILIATIONS

a. Are you in the employ of any individual, firm or corporation other than your own? [] Yes [] No
 If yes, please provide a detailed explanation including details of your responsibilities.

b. Are you under contract to any individual, firm or corporation other than you own? [] Yes [] No
 If yes, please provide a detailed explanation including details of your responsibilities.
 (If your contract contains a hold-harmless agreement, a copy of the contract must be attached to this application).

c. Are you in the employ of, or under contract to, any governmental entity? [] Yes [] No
 If yes, please provide a detailed explanation including details of your responsibilities.

d. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? [] Yes [] No
 If yes, please submit a copy of your advertisement.

e. Are you associated with any agency or organization that engages in advertising for, or solicitation of, patients? [] Yes [] No
 If yes, please submit a copy of ALL advertisements.

5. CLAIMS

(Attach a detailed explanation for any "yes" answers).

a. Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? [] Yes [] No
 (Attach a copy of the Complaint and Consent Order, if applicable)

5. CLAIMS (CONTD.)

<p>b. Have you ever been convicted for an act committed in violation of any law or ordinance. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>f. Have you ever failed any medical licensing or specialty organization examination? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>c. Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital, or professional association requested or required that you be evaluated for any alleged mental condition and/or alcohol or drug addiction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>g. Do you have any chronic physical illness or defect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, complete a Supplemental Claim Information form.</p>
<p>d. Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>i. Has any claim or suit for alleged malpractice been brought against you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, complete a Supplemental Claim Information form.</p>
<p>e. Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>j. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please complete a Supplemental Claim Information form.</p>

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Shand Morahan Plaza, Evanston, Illinois 60201.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

Quaker Special Risk

a division of the Quaker Agency Inc.

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet,
2. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

- 1 Applicant Name _____
- 2 Claimant Name _____
- 3 Name of Individual(s) at your firm/Company Involved in Claim: _____
- 4 Indicate whether: _____ Claim/Suit _____ Incident
- 5 Date of alleged error: _____ Date claim made against applicant: _____
- 6 Additional defendants: _____
- 7 Current Disposition of claim-
 - DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
 - ABANDONED (no activity from claimant for over 3 years)
 - WON by defense
 - WON by claimant Total Paid \$ _____ Amount Paid on your behalf \$ _____
 - Indicate whether : Court judgment, or Out of court settlement
 - OPEN Claimant's settlement demand \$ _____
 - Defendants offer for settlement? \$ _____ Insurer's loss reserve \$ _____
8. Name of Insurer: _____
9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
 - a. Alleged act, error or omission upon which Claimant bases claim: _____
 - b. Description of cases and events:
 - c. Description of the type and extent of injury or damage allegedly sustained:
 - d. If a medical claim provide type of injury claimed:
 - Emotional Only Temporary Disability Death Cosmetic
 - Permanent Disability Other (describe) _____
- IO. Explain what action has been taken by you to prevent recurrence of the same type of claim.

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

Name of Applicant*

Title

Signature of Applicant

Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.

Quaker Special Risk a division of the Quaker Agency Inc.

APPLICANT'S INSTRUCTIONS

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. This is a mandatory form which must accompany a completed application and supplemental claim information form.
3. PLEASE READ THE STATEMENTS AT THE END OF THIS APPLICATION CAREFULLY.
(PLEASE TYPE OR PRINT IN INK)

1. NAME OF APPLICANT _____

2. APPLICANT HISTORY _____

- | | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| a. Are you aware of any act, error, omission or circumstance which could result in a malpractice claim or suit being made against you? | [] | [] |
| If Yes, has this been reported to a prior carrier? | [] | [] |
| SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such medical incident or threat of claim; have you attached the completed form? | [] | [] |

b. To the best of your knowledge, have any of the following adverse results occurred in your practice in the last (5) years:

	<u>Yes</u>	<u>No</u>
--	------------	-----------

- | | | |
|--|-----|-----|
| (i) Unexpected death (including stillbirths)? | [] | [] |
| (ii) Unexpected organ failure or significant neurological or functional deficit? | [] | [] |
| (iii) Failure to diagnose cancer or infection resulting in death or disability of patient? | [] | [] |
| (iv) Tear or perforation of an organ or body part during an invasive procedure, or unplanned removal of a normal organ or body part during an operative procedure? | [] | [] |
| (v) Suspicious or positive x-ray, Pap smear or mammogram where patient was not contacted? | [] | [] |
| (vi) Follow-up/emergency surgery, myocardial infarction or cerebral vascular accident within 48 hours of your previous diagnostic treatment or surgery? | [] | [] |
| (vii) Complications from improper medication or improper dosage? | [] | [] |
| (viii) Pathological and/or operative report which do not match? | [] | [] |

If yes to any of the above, has it been reported to a prior carrier? [] []

If you have NOT reported to a prior carrier, please attach an explanation.

SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result; have you attached the completed form? [] []

- | | | |
|---|-----|-----|
| c. Has any attorney contacted you (e.g., request for medical records) in connection with any patient that has NOT been disclosed to us? | [] | [] |
| If yes, SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result; have you attached the completed form? | [] | [] |

- | | | |
|---|-----|-----|
| d. Does your current professional liability carrier require reporting of an incident or request for records by a patient or attorney? | [] | [] |
|---|-----|-----|

Yes **No**

- | | | |
|---|-----|-----|
| e. Has any prior professional liability carrier refused coverage for, or declined to accept your report of, a medical incident, threat of claim, adverse result or attorney contact'? | [] | [] |
| If yes, please attach an explanation. | | |

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

Name of Applicant*

Title

Signature of Applicant

Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.

(FAX

NAME: _____
COMPANY: _____
ADDRESS: _____
STATE, ZIP: _____
DATE: _____
NUMBER OF PAGES(incl. Cover): _____
* FAX TO: _____

PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST YOU.

* Click the link below for a list of our offices and current fax numbers.

<http://www.qsr-insurance.com/qsr-fax.html>

ADDITIONAL COMMENTS:

