



NEW BUSINESS APPLICATION
PROFESSIONAL LIABILITY INSURANCE
PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE

- General Star Indemnity Company
 General Star National Insurance Company

Please complete this application in ink and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

INSTRUCTIONS TO THE APPLICANT:

- You must provide a fully completed application, signed and dated by you within 45 days of the desired effective date of coverage.
- Appropriate Supplementary Applications, Claim Information Supplement(s) and additional documentation must also be completed as needed.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The following additional information must be provided:
 - Copy of your current professional liability insurance Declarations Page.
 - Copy of your Curriculum Vitae.
 - Copies of all advertising that you use.
 - Copy of your business letterhead.
 - Company loss runs, valued within the last 90 days.

I. GENERAL INFORMATION

Social Security #: _____

Applicant's Name: _____ Date of Birth: _____

Professional Designation: M.D. D.O. D.P.M. Other (describe) _____

1. Mailing Address: _____
 Street/P.O. Box _____ City _____ County _____ State _____ Zip Code _____

2. Primary Practice Location: _____ Number of years at this location: _____
 Street _____ City _____ County _____ State _____ Zip _____

Do you have more than one practice location? **If YES**, on a separate sheet please provide the following information: location address, hours of operation, procedures performed at each location, number of years at each location. Yes No

3. Office Telephone: _____ E-mail: _____
 Office facsimile: _____ Web Site: _____

4. Applicant is a(n): Individual Corporation LLC Partnership
 Employed Physician By Whom _____
 Other (describe): _____
 Practice is a: Solo Practice Group Practice
 Entity Name: _____ Applicant's percentage of ownership: ____%
 How many other physicians practice at this entity? _____
 Do you use any "doing business as" (d/b/a) name? Yes No
If YES, specify: _____

5. Residence Address: _____
 Street/P.O. Box _____ City _____ County _____ State _____ Zip Code _____
 Residence Telephone: _____

II. MEDICAL TRAINING & EDUCATION

1. Medical Specialty: _____ Percentage of Practice: _____%
 Sub-Specialty: _____ %

2. Date you began practicing medicine: _____

3.	Hospital / College	City & State	Completed?	Dates – From / To
Medical School			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Internship			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Residency			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Residency			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fellowship			<input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Are you a U.S. citizen? **If NO**, please provide a copy of documents confirming your status. Yes No

5. Are you a Foreign Medical School Graduate? **If YES**, please provide: Yes No
 Date of ECFMG certification: _____

6. Are you currently Certified by any board recognized by the **American Board of Medical Specialties**? **If YES**, please provide: Yes No
 Name of Board: _____ Certificate expiration: _____

7. Are you a member of any medical association? **If YES**, please list memberships: Yes No

8. Please indicate the number of CME hours you have completed in the past two years: _____

III. MEDICAL PRACTICE HISTORY

1. Within the last five (5) years have your practice characteristics, procedures performed, or business association(s) changed? **If YES**, please describe on additional sheet. Yes No

2. List all primary office locations where you have practiced in the last ten (10) years.
(Use separate sheet if more space is needed)

Street Address & City	County	State	Dates – From / To

3. List all hospitals where you have staff privileges:
(If no hospital privileges, attach protocol for patient hospital admission)

Hospital	City / State	County	% of Practice	Type of privilege

4. List all states where you practice or have a medical license:	Medical License Number(s):	DEA License Number(s):	% of practice in each state:

5. Legal / Professional / Administrative Actions against you:
- a. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? **If YES**, please describe on separate sheet. Yes No
 - b. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? **If YES**, please describe on separate sheet. Yes No
 - c. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If YES**, please explain on a separate sheet. Yes No
 - d. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? **If YES**, please complete **Substance Impairment Supplemental Application**. Yes No
 - e. Have you ever been charged with, or convicted of a crime other than minor traffic violations? **If YES**, please explain on a separate sheet. Yes No
 - f. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s), or a state licensing authority? **If YES**, please explain on a separate sheet. Yes No

IV. OFFICE STAFF

1. Do you employ, contract with, or supervise any **physician(s) or surgeons(s)**? Yes No
If YES, enter information below and attach current certificate(s) of insurance.

Physician/Surgeon Name	Medical Specialty	Limits of Liability	Employ (E) Contract (C) Supervise (S)	Insurer
			<input type="checkbox"/> E <input type="checkbox"/> C <input type="checkbox"/> S	
			<input type="checkbox"/> E <input type="checkbox"/> C <input type="checkbox"/> S	
			<input type="checkbox"/> E <input type="checkbox"/> C <input type="checkbox"/> S	
			<input type="checkbox"/> E <input type="checkbox"/> C <input type="checkbox"/> S	

2. Do you employ, contract with, or supervise any non-physician health care extenders? Yes No
If YES, enter information below:

TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY	TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY
Midwife			Medical Lab Technician		
CRNA			Pharmacist		
Nurse Practitioner			Nurse (RN/LPN)		
Physician Assistant			X-Ray Technician		
Surgeon Assistant			Physical Therapist		
Optometrists					

OTHER (Please provide detail on separate page)

V. PROCEDURES/PRACTICE SPECIFICS

- | | | |
|--|---|--|
| 1. a. Average Weekly Patient Encounters: | | |
| b. Average Weekly Practice Hours: | | |
| c. Percentage Of Locum Tenens Work: | % | |
2. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center? Yes No
If YES, please describe on separate sheet.

3. Does your practice include the following? Check all that apply.																						
<input type="checkbox"/>	No Surgery	No surgery with the exception of: suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.																				
<input type="checkbox"/>	Minor Surgery	Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: <ul style="list-style-type: none"> ▪ Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP), ▪ Pneumatic or mechanical esophageal dilation (not with bougie or olive), ▪ Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists who have completed a cardiovascular subspecialty training.), ▪ Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue, ▪ Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae No procedures performed on a patient while under general anesthesia.																				
<input type="checkbox"/>	Major Surgery	Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography and radiation therapy. It also includes removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.																				
<input type="checkbox"/>	Gynecology / Obstetrics	If checked, please indicate which procedures: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Office Gynecology only</td> <td><input type="checkbox"/> Elective Abortions</td> </tr> <tr> <td><input type="checkbox"/> Pre-natal care through 1st trimester only</td> <td>Number each month _____</td> </tr> <tr> <td><input type="checkbox"/> Pre-natal care through 2nd trimester only</td> <td>Maximum Gestation Age _____</td> </tr> <tr> <td><input type="checkbox"/> Pre-natal care full term</td> <td>Where performed _____</td> </tr> <tr> <td><input type="checkbox"/> Amniocentesis</td> <td><input type="checkbox"/> Therapeutic Abortions</td> </tr> <tr> <td><input type="checkbox"/> High Risk Pregnancies</td> <td>Number each month _____</td> </tr> <tr> <td><input type="checkbox"/> Toxemia Management</td> <td>Maximum Gestation Age _____</td> </tr> <tr> <td><input type="checkbox"/> Dilation and Curettage</td> <td>Where performed _____</td> </tr> <tr> <td><input type="checkbox"/> Cryosurgery</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Norplant Insertion</td> <td></td> </tr> </table>	<input type="checkbox"/> Office Gynecology only	<input type="checkbox"/> Elective Abortions	<input type="checkbox"/> Pre-natal care through 1 st trimester only	Number each month _____	<input type="checkbox"/> Pre-natal care through 2 nd trimester only	Maximum Gestation Age _____	<input type="checkbox"/> Pre-natal care full term	Where performed _____	<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Therapeutic Abortions	<input type="checkbox"/> High Risk Pregnancies	Number each month _____	<input type="checkbox"/> Toxemia Management	Maximum Gestation Age _____	<input type="checkbox"/> Dilation and Curettage	Where performed _____	<input type="checkbox"/> Cryosurgery		<input type="checkbox"/> Norplant Insertion	
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<input type="checkbox"/>	Obstetrics	Indicate annual number of: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Vaginal Deliveries: _____</td> <td><input type="checkbox"/> Cesarean Sections: _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> VBAC Deliveries: _____</td> </tr> <tr> <td>Indicate the percentage of:</td> <td><input type="checkbox"/> Non-Hospital Deliveries _____</td> </tr> <tr> <td>Low forceps deliveries _____%</td> <td>(Please describe circumstances on separate sheet)</td> </tr> <tr> <td>Mid forceps deliveries _____%</td> <td><input type="checkbox"/> Episiotomies: _____</td> </tr> <tr> <td>Breech Deliveries _____%</td> <td></td> </tr> </table> Do you personally attend each delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No Does a Midwife perform any actual deliveries/births? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , annual number performed by Midwife: _____	<input type="checkbox"/> Vaginal Deliveries: _____	<input type="checkbox"/> Cesarean Sections: _____		<input type="checkbox"/> VBAC Deliveries: _____	Indicate the percentage of:	<input type="checkbox"/> Non-Hospital Deliveries _____	Low forceps deliveries _____%	(Please describe circumstances on separate sheet)	Mid forceps deliveries _____%	<input type="checkbox"/> Episiotomies: _____	Breech Deliveries _____%									
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Mid forceps deliveries _____%	<input type="checkbox"/> Episiotomies: _____																					
Breech Deliveries _____%																						
<input type="checkbox"/>	Radiology	<input type="checkbox"/> Diagnostic <input type="checkbox"/> Interventional Annual number of readings performed: _____ Type of readings performed: _____ Do you perform any non-physician-referred screening mammographies? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , on a separate page, please describe your procedures for assuring continuity of care/follow up. Do you read, interpret, and/or diagnose films, electronic images, or slides of patients residing in any state(s) other than your primary practice state address? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , specify on additional pages the state(s), percentage of your total practice, and other pertinent details.																				

<input type="checkbox"/>	Anesthesia/ Office Surgery	<p>Performance or assistance in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis.</p> <p>Indicate annual number and description of procedures:</p> <table border="1" data-bbox="456 205 1503 336"> <thead> <tr> <th></th> <th style="text-align: center;">#</th> <th style="text-align: center;"><u>Description of Procedures</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> General Anesthesia</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Spinal or Caudal Anesthesia</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Anesthesia administered by: _____ Distance to nearest hospital: _____ Description of life saving equipment/supplies: _____</p>		#	<u>Description of Procedures</u>	<input type="checkbox"/> General Anesthesia	_____	_____	<input type="checkbox"/> Spinal or Caudal Anesthesia	_____	_____	<input type="checkbox"/> Other	_____	_____
	#	<u>Description of Procedures</u>												
<input type="checkbox"/> General Anesthesia	_____	_____												
<input type="checkbox"/> Spinal or Caudal Anesthesia	_____	_____												
<input type="checkbox"/> Other	_____	_____												
<input type="checkbox"/>	Elective Plastic Surgery	Describe procedures and annual number performed on separate sheet.												
<input type="checkbox"/>	Pain Management	<p>Check the procedures that you perform:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blocks <input type="checkbox"/> Epidurals <input type="checkbox"/> Trigger Point Injections <input type="checkbox"/> Surgically Implanted Devices <p>Do you prescribe synthetic opiates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES,</p> <p>a. Indicate the annual number of prescriptions written: _____</p> <p>b. On a separate sheet, describe your controls in place to reduce or eliminate drug-seeking behavior.</p>												
<input type="checkbox"/>	Alternative Medicine	Describe procedures and annual number performed on separate sheet.												
<input type="checkbox"/>	Weight Control/ Bariatrics	<p>On a separate sheet, describe procedures for weight reduction/control by other than diet and exercise.</p> <p>Percentage of patients treated exclusively for weight control _____%</p> <p>List injections used for weight control: _____</p> <p>If you prescribe or dispense drugs for weight control, please list drugs and describe protocols: _____</p> <p>Complete the Bariatric Surgery Supplemental Application.</p>												
<input type="checkbox"/>	Podiatry	<p>Check the procedures that you perform:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reduction of simple fractures of the heel or ankle <input type="checkbox"/> Reduction of compound factures of the heel or ankle <input type="checkbox"/> Use of lasers <input type="checkbox"/> Cutting or penetration of tissue other than that as defined as "No Surgery" above <input type="checkbox"/> Arthrodesis <input type="checkbox"/> Permanent removal of nail plate except by the use of electrical or chemical cautery <input type="checkbox"/> Surgical procedures of the ankle joint which includes any of the following: <ul style="list-style-type: none"> ▪ Tibia and/or fibula and their related structures ▪ Arthroplasty ▪ Grafts and/or implants <input type="checkbox"/> Surgical treatment of the muscles and tendons at the level of the ankle joint <input type="checkbox"/> Any other surgical procedures performed on the foot and/or ankle <p>Please describe: _____</p> <p>_____</p>												

4. Please check any procedures that you perform:	
<input type="checkbox"/> Abortions	<input type="checkbox"/> Kidney, Ureter and Bladder Surgery
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Laparoscopies
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Laser Treatments Via Endoscope
<input type="checkbox"/> Amputations	<input type="checkbox"/> Liposuction Procedures
<input type="checkbox"/> Anal Fissure	<input type="checkbox"/> Malignant Lesion Surgical Procedures
<input type="checkbox"/> Angiography	<input type="checkbox"/> Mastoidectomy
<input type="checkbox"/> Arterial Catheterization	<input type="checkbox"/> Middle or Inner Ear Surgery
<input type="checkbox"/> Arteriography	<input type="checkbox"/> MOHS Micrographic Surgery
<input type="checkbox"/> Assisting in surgery on other than your own patients	<input type="checkbox"/> Myelography
<input type="checkbox"/> Assisting in surgery on your own patients	<input type="checkbox"/> Needle Biopsies
<input type="checkbox"/> Bariatric Surgeries	<input type="checkbox"/> Neurological Surgery
<input type="checkbox"/> Blepharoplasty	<input type="checkbox"/> Norplant Insertion
<input type="checkbox"/> Breast Implants, Augmentation or Reduction	<input type="checkbox"/> Obesity/Weight Control Surgery
<input type="checkbox"/> Cardiac Catherizations	<input type="checkbox"/> Office Gynecology
<input type="checkbox"/> Cervical Biops?	<input type="checkbox"/> Oophorectomy
<input type="checkbox"/> Cervical Cautery	<input type="checkbox"/> Open Reduction of Fractures (Plating and Pinning)
<input type="checkbox"/> Chelation Therapy – for cardiac care	<input type="checkbox"/> Ophthalmologic Surgery
<input type="checkbox"/> Chelation Therapy – for heavy metal poisoning	<input type="checkbox"/> Ophthalmologic Surgery (LASIK)
<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Orchidectomy
<input type="checkbox"/> Cleft Lip or Palate Surgery	<input type="checkbox"/> Organ Transplants
<input type="checkbox"/> Clinical Trials	<input type="checkbox"/> Orthopedic Surgery (Including Spinal Surgery)
<input type="checkbox"/> Closed Reduction of Fractures	<input type="checkbox"/> Orthopedic Surgery (No Spinal Surgery)
<input type="checkbox"/> Cholecystectomies	<input type="checkbox"/> Otoplasty
<input type="checkbox"/> Collagen Lip Injection	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Pedicle Screw Insertion
<input type="checkbox"/> Complex Flaps and Grafts	<input type="checkbox"/> Penile Augmentation
<input type="checkbox"/> Conization of Cervix	<input type="checkbox"/> Penile Implants
<input type="checkbox"/> Culdocentesis	<input type="checkbox"/> Pericardiocentesis
<input type="checkbox"/> Diagnostic Radiology	<input type="checkbox"/> Permanent Eyeliner Procedures
<input type="checkbox"/> Electroshock Therapy	<input type="checkbox"/> Photorefractive Keratotomy
<input type="checkbox"/> Endometrial Biopsy	<input type="checkbox"/> Pregnancy Care into Second Trimester
<input type="checkbox"/> Endoscopic Retrograde / Cholangiopancreatography	<input type="checkbox"/> Pregnancy Care into Third Trimester
<input type="checkbox"/> Experimental Procedures	<input type="checkbox"/> Prostatectomy
<input type="checkbox"/> Gastric Bubble Procedures	<input type="checkbox"/> Radial Keratotomy
<input type="checkbox"/> Hair Transplant Procedures	Annual number of procedures: _____
<input type="checkbox"/> Hemorrhoidectomies	<input type="checkbox"/> Radiation Therapy (Radium Implants)
<input type="checkbox"/> Hernioplasty	<input type="checkbox"/> Reconstructive Plastic Surgery
<input type="checkbox"/> Hyperbaric Chamber Treatments	<input type="checkbox"/> Salpingectomy
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Scalp Reduction Surgery
<input type="checkbox"/> Hysterectomies	<input type="checkbox"/> Sex Change Operations
<input type="checkbox"/> Interphalangeal Joint Surgery	<input type="checkbox"/> Sterilization Procedures
<input type="checkbox"/> Joint Replacement Surgery	<input type="checkbox"/> Thrombectomy of Arteries and Veins
	<input type="checkbox"/> Tubal Ligation
	<input type="checkbox"/> Vascular Surgery
	<input type="checkbox"/> Other, List _____
5. Do you own or operate a Laboratory? If YES,	
a. Does the laboratory provide services <u>solely</u> for your patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If not limited to your patients, please explain on separate sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. a. Are you now performing experimental or investigational procedures or prescribed/dispensed experimental drugs?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES to either of the above, please explain on a separate sheet.	
7. a. Do you now treat prisoners in a state, federal or any correctional institution?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please complete the Correctional Facility Supplemental Application.	
b. Have you ever treated prisoners in a state, federal or any correctional institution?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please provide last date of treatment. _____	

8. Do you practice as a company doctor (excluding treatment of workers compensation patients)? **If YES,** Yes No
- a. What products are manufactured by the company? _____
- b. Do you review or establish plant / employer safety standards? Yes No
- c. Do you provide medical treatment to company employees? Yes No
- d. Company name: _____ Location: _____

10. a. Do you work in an Emergency Room? Yes No
- b. **If YES,** is this solely to satisfy requirements for hospital privileges? Yes No
- c. Indicate the average number of hours you work in the Emergency Room each month: _____

11. Are you a sports team physician or health care provider? **If YES,** check all that apply: Yes No
- High School College Professional Other: _____
- Name and location of team(s): _____

12. Do you treat patients in a Nursing Home or a similar care facility? Yes No
- If YES,** how many patients currently reside in a Nursing Home or similar care facility? _____

13. Indicate if you now, or have ever been, any of the following at any Nursing Home, Hospital, Hospital Department, Sanitarium, HMO, PPO, Ambulatory Care Clinic with bed and board facilities, or any other business enterprise?

	Now	% of Practice	In the Past	% of Practice	Type of Facility (identify from list above)
Proprietor	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Partner	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Officer	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Director	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Administrator	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Executive Director	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Medical Director	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Contractor	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Provider of Services	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	
Employee	<input type="checkbox"/>	_____%	<input type="checkbox"/>	_____%	

If YES, provide name(s) of facilities and explain details:

14. Do you serve in a "Gatekeeper" capacity (that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization)? Yes No
- If YES,** please advise of percentage of your practice devoted to Gatekeeper activity: _____%

15. Do you engage in tele-medicine activity? **If YES,** do you outsource radiology "reads" to another source? **If YES,** identify source, location, and licensing credentials of that other source. Yes No
- _____

16. Do you prescribe drugs or provide diagnosis via the Internet? **If YES,** please describe on separate sheet. Yes No

17. Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)? **If YES,** please describe on separate sheet. Yes No

VI. PRIOR POLICY AND LOSS INFORMATION

1. Please provide the following information pertaining to your past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium	* Total # of Claims
				<input type="checkbox"/> CM <input type="checkbox"/> Occ		
				<input type="checkbox"/> CM <input type="checkbox"/> Occ		
				<input type="checkbox"/> CM <input type="checkbox"/> Occ		
				<input type="checkbox"/> CM <input type="checkbox"/> Occ		
				<input type="checkbox"/> CM <input type="checkbox"/> Occ		

***Total # of claims, by carrier, regardless of payment, no-payment, dismissal or status.**

2. Have you ever practiced without professional liability insurance? Yes No
If YES, specify dates: from _____ until _____

3. Have you ever had any insurance company decline, cancel, rescind or non-renew any Professional Liability Insurance Policy? Yes No
(Response not required in the State of Missouri)
If YES, please provide details:

4. Are you aware of any of the following:

- a. known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? Yes No
- b. facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that has not been reported to a prior insurance carrier? Yes No
- c. any request for medical records by a patient or his/her attorney which might result in a claim? Yes No
- d. information relating to service(s) on a Board which might result in a claim? Yes No
- e. any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, claim, threat of claim, letter of intent, adverse result notice or attorney contact? Yes No
- f. any involvement, now or ever, in any Professional Liability claim or suit? Yes No
If YES, a **Claim Information Supplemental Application** *must* be completed for each claim.

If YES to any of the above, please provide details:

VII. COVERAGE REQUESTED

NOTE: The Company may not offer or quote requested coverage.

Effective Date: _____ **Retroactive Date:** _____
Important: Declarations Page of your current policy must be attached if a retroactive date is requested.

Limits of Liability:

- \$ 100,000 / \$ 300,000
- \$ 200,000 / \$ 600,000
- \$ 250,000 / \$ 750,000
- \$1,000,000 / \$3,000,000
- Other \$ _____

Deductible:

- \$ 5,000 (minimum)
- \$ 7,500
- \$10,000
- \$15,000
- Other \$ _____

VIII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and
2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):

<input type="checkbox"/> Substance Impairment Supplemental Application	<input type="checkbox"/> Correctional Facility Supplemental Application
<input type="checkbox"/> Bariatric Surgery Supplemental Application	<input type="checkbox"/> Statement of No Known Claims Letter
<input type="checkbox"/> Claim Information Supplemental Application	<input type="checkbox"/> Other _____
3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:
 - a. Accurate, true and complete to the best of your knowledge;
 - b. No material facts have been suppressed or misstated;
 - c. Representations you are making on behalf of all persons and entities proposed to be insured;
 - d. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.
5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

NEW YORK FRAUD WARNING: 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.

FRAUD WARNING (not applicable in Nebraska, Vermont or Virginia): Any person who knowingly and with the 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a “non-admitted” or “surplus lines” insurer in all states except Connecticut (where General Star National Insurance Company is “non-admitted or “surplus lines”), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

Signature of Applicant

Date

Print or Type Name and Title



GENERAL STAR INDEMNITY COMPANY

CLAIM INFORMATION SUPPLEMENT

PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE

This Claim Information Supplement must be completed, signed and dated by the applicant for each claim, suit or circumstance reported on your application for insurance. All questions must be answered completely. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please attach a separate page. Photocopy this form and use a separate one for each claim, suit, or circumstance.

Physician Information:

PHYSICIAN NAME: SOCIAL SECURITY NUMBER:

Claim or Circumstance Information:

CLAIMANT/PATIENT NAME: AGE: SEX:
DATE OF ALLEGED INCIDENT: DATE CLAIM WAS MADE OR SUIT BROUGHT:
ADDITIONAL DEFENDANTS:
INSURANCE CARRIER TO WHOM CLAIM/CIRCUMSTANCE REPORTED:

Claim Status:

DISMISSED DEFENSE VERDICT
PLAINTIFF VERDICT TOTAL PAID \$ PAID ON YOUR BEHALF \$
SETTLEMENT TOTAL PAID \$ PAID ON YOUR BEHALF \$
OPEN
SETTLEMENT DEMAND \$ SETTLEMENT OFFER \$ LOSS RESERVE \$

(For all Paid & Reserve amounts, include both Indemnity and Expense dollars.)

Claim Description: (Include allegation(s), events leading up to the claim, diagnosis, treatment, results of treatment and any other facts pertinent to the claim.)

[Empty text area for claim description]

The applicant declares that the information contained in this CLAIM INFORMATION SUPPLEMENT is true and that no material facts have been suppressed or misstated. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature _____ Date _____

Printed Name _____