MedPro Group
a Berkshire Hathaway company

Issuing Company:
The Medical Protective Company
Fort Wayne, Indiana

PHYSICIAN APPLICATION

INSTRUCTIONS

1. Please answer all questions. If a question is not applicable, print, "n/a".
2. This application must be completed and signed by an authorized officer of the applicant.
3. If additional space is needed, please use the Supplemental Information section at the end of the application and refer to the question or an additional form.

COVERAGE DESIRED

CLAIMS-MADE COVERAGE NOTICE:

Claims-Made coverage is generally limited to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact the applicant's agent should the applicant have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".

Coverage Desired:

☐ Claims-Made coverage without Prior Acts coverage
☐ Claims-Made coverage with Prior Acts coverage
☐ Occurrence coverage
☐ Occurrence coverage with Prior Acts coverage

If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

☐ An extended reporting endorsement (tail coverage) has been or will be purchased.
☐ An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying with The Medical Protective Company, if offered, will not provide Prior Acts coverage.

_____
INITIAL HERE

I. GENERAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name: _____ Suffix: _____

B. **Joining As:** _____

☐ Employee ☐ Contractor ☐ Other: _____ Date joined: ___/___/_____
MM DD YYYY

Social Security #: _____

C. **Residence Address:**

Number and Street: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

County: _____

II. EDUCATIONAL BACKGROUND

A. **Medical School:**

_____ _____
Name of School Degree

_____ _____ Completed From: ___/____ To: ___/____
City State MM YYYY MM YYYY

Country: _____

B. **If a foreign medical school graduate, is the applicant certified by the Educational Commission for Foreign Medical Graduates or has the applicant completed the Fifth Pathway Program?** ☐Yes ☐No

If No, please explain: _____

_____

C. **Residency: List all residency training programs.** Please enter each specific specialty.

1. Name of Hospital/Facility/Program: _____

City: _____ State: _____ Country: _____

Specialty type: _____

Completed: ☐Yes ☐No ☐Still in training From (MM/YYYY): ___/_____ To (MM/YYYY): ___/_____

II. EDUCATIONAL BACKGROUND (continued)

2. Name of Hospital/Facility/Program: _____

City: _____ State: _____ Country: _____

Specialty type: _____

Completed: ☐Yes ☐No ☐Still in training From (MM/YYYY): __/____ To (MM/YYYY): __/____

D. Has the applicant participated in any additional training? (i.e. Fellowship, etc.) ☐Yes ☐No

If Yes, please provide the following information:

1. Name of Hospital/Facility/Program: _____

City: _____ State: _____ Country: _____

Specialty type: _____

Completed: ☐Yes ☐No ☐Still in training From (MM/YYYY): __/____ To (MM/YYYY): __/____

2. Name of Hospital/Facility/Program: _____

City: _____ State: _____ Country: _____

Specialty type: _____

Completed: ☐Yes ☐No ☐Still in training From (MM/YYYY): __/____ To (MM/YYYY): __/____

E. Is the applicant entering practice for the first time? ☐Yes ☐No

F. If the applicant has participated in continuing medical education within the last 3 years, indicate the number of Category 1 credit hours: _____

G. Has the applicant completed a risk management education course within the last 12 months? ☐Yes ☐No

III. PRACTICE INFORMATION

A. Does the applicant perform consultations, render medical services, medical opinions, or give medical advice outside the state of the applicant's primary location, including but not limited to, Telemedicine or Internet Medicine? ☐Yes ☐No
If this is covered by another professional liability insurance policy, complete Question G of the Additional Professional Information section.

If Yes, which state(s): _____

B. States in which the applicant holds a license to practice medicine:
Please check the appropriate box to indicate the status of the applicant's license.

(Exclude state abbreviation from license number)	Active	Inactive	Temporary	Pending
1. State:_____ License #:_____	☐	☐	☐	☐
2. State:_____ License #:_____	☐	☐	☐	☐
3. State:_____ License #:_____	☐	☐	☐	☐
4. State:_____ License #:_____	☐	☐	☐	☐

C. Does the applicant have previous practice location(s)? ☐Yes ☐No
If Yes, list all location(s) within the past 10 years. If the applicant's requested retroactive date is greater than 10 years, provide locations back to the retroactive date. Please list the most recent location first.

1. Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty type: _____ From (MM/YYYY): __/____ To (MM/YYYY): __/____

2. Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty type: _____ From (MM/YYYY): __/____ To (MM/YYYY): __/____

D. Please explain the following gaps if they occurred in the last 10 years:

1. Gaps greater than 1 year between the applicant's medical school, residency, other training or first time in practice: _____

2. Gaps greater than 6 months between practice locations: _____

E. To which medical societies or associations does the applicant belong? _____

Note: All percentages requested below for specialties, procedures and surgical activities are of the applicant's total practice.

Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.

F. What is the applicant's present specialty? _____ ____ % of total practice

What is the applicant's sub-specialty? _____ ____ % of total practice

G. Is the applicant permanently retired from the practice of clinical medicine? ☐Yes ☐No

III. PRACTICE INFORMATION (continued)

H. American Board Certified? ☐Yes ☐No _____ ___/____(MM/YYYY)
Specialty Board — Date most recently certified.

_____ ___/____(MM/YYYY)
Specialty Board — Date most recently certified.

If not American Board Certified, is the applicant board eligible? ☐Yes ☐No

If Yes, when does the applicant take the applicant's boards? ___/_____ (MM/YYYY)

If not American Board Certified, has the applicant ever taken a specialty board examination and failed to pass? ☐Yes ☐No

If Yes, how many times?_____

If Yes, please explain: _____

_____

I. Indicate the state and county where the applicant practices, and average weekly hours at that location:
State(s)/County(ies): _____ Hours: _____ State(s)/County(ies): _____ Hours: _____

J. Indicate the estimated average weekly numbers, under each of the following categories, for which the applicant requires the Company's coverage:
Hours per week: _____ Patients seen per week: _____ ☐ None Unscheduled walk-in patients per week: _____ ☐ None

K. Please indicate the percentage of the applicant's total practice performing the following surgical activities:

___ % Cardiac ___ % Obstetrics ___ % Otolaryngology ___ % Traumatic
___ % Gynecology ___ % Ophthalmology ___ % Plastic (cosmetic enhancement only) ___ % Urology
___ % Hand ___ % Orthopedic (including back) ___ % Plastic (reconstruction only) ___ % Vascular
___ % Neurosurgery ___ % Orthopedic (not including back) ___ % Thoracic
___ % Other: (describe) _____

L. Please check any of the following procedures the applicant will perform:

☐ Abdominoplasty – Tummy Tuck
☐ Abortions – Elective____% of total practice
☐ Abortions – Therapeutic ____% of total practice
☐ Acupuncture – Therapeutic/Local Anesthetic
☐ Anesthesia General/Spinal/Caudal
☐ Angiography
☐ Angioplasty
☐ Arteriography
☐ Arthroscopy
☐ Assisting in major surgery – own patients only
☐ Assisting in major surgery – own & other than own patients
☐ Bariatric Surgery – Laparoscopic
☐ Bariatric Surgery – Non-Laparoscopic
☐ Biopsy – Endoscopic
☐ Blepharopigmentation ____ % of total practice
☐ Blepharoplasty – Cosmetic ____% of total practice
☐ Blepharoplasty – Reconstruction____ % of total practice
☐ Botox____ % of total practice
☐ Brachioplasty
☐ Breast Implants – Cosmetic ____% of total practice
☐ Breast Implants – Reconstruction ____% of total practice
☐ Breast Reduction – Cosmetic
☐ Bronchoscopy
☐ Bronco-esophagology
☐ Buttock Implants
☐ Calf Implants
☐ Cataract Surgery
☐ Catheterization – Left Heart
☐ Catheterization – Right Heart (other than CVP lines)/ Swanz Ganz
☐ Cheek/Chin/Lip Implants
☐ Chelation Therapy
☐ Chemical Peels – Superficial/Medium
☐ Chemical Peels – Deep ____% of total practice
☐ Cleft Lip Surgery – Reconstructive
☐ Cleft Palate Surgery – Reconstructive
☐ Colonoscopy
☐ Cryosurgery (Cervical)
☐ Cryosurgery (non-external lesions)
☐ D & C
Disectomy
  ☐ Open
  ☐ Other Than Open
☐ Electromagnetic Therapy
☐ Electroconvulsive/Shock Therapy
☐ Embolization
☐ ERCP
☐ Face Lifts
☐ Face Lifts Mini (done with laser) ____ % of total practice
☐ Gastrointestinal Endoscopy
☐ Gynecology – Major Surgery
☐ Hair Transplants – Follicular Unit Transplantations
☐ Hair Transplants – Other
☐ HVLA on the cervical spine on patients younger than 18 years of age
☐ Intrathecal Pumps
☐ Kyphoplasty
☐ Laparoscopic Cholecystectomy
☐ Laparoscopy
☐ Laser Surgery
☐ Laser Therapy (Endoscopic)
☐ Laser Therapy (Non-Endoscopic)
☐ Lipoinjection ____% of total practice
Liposuction
  ☐ Other Than Tumescent Technique
  ☐ Tumescent Technique Only____% of total practice
☐ Lithotripsy
☐ Lymphangiography
☐ Mammograms
☐ Myelography
Nerve Blocks
  ☐ Facet
  ☐ Lumbar Epidural Steroid
  ☐ Myofascial
  ☐ Occipital
  ☐ Paraspinal/Paravertebral
  ☐ Peripheral
  ☐ Sciatic
  ☐ Triggerpoint Injection
☐ Oxidation Therapy
☐ Pacemakers – Epicardial
☐ Pacemakers – Endocardial
☐ Pacemakers – Temporary
☐ Peritoneoscopy
☐ Phlebography
☐ Pneumoencephalography
☐ Polypectomy
Prenatal/Gynecological Practice
  ☐ Prenatal Practice – 1st & 2nd Trimester
  ☐ Prenatal Practice – to term, no delivery
  ☐ Prenatal Practice – to term and delivery
  ☐ Normal Deliveries-total per year ____
  ☐ Cesarean Deliveries-total per year____
☐ Prolotherapy
☐ Radial/Laser Therapy
☐ Radiation/X-Ray Therapy
☐ Rectal Ozone Therapy
☐ Rhinoplasty ____ % of total practice
☐ Sigmoidoscopy – 60 cm or less
☐ Sigmoidoscopy – greater than 60 cm
☐ Silicone Injections ____% of total practice
Skin Flaps/Grafts
  ☐ Cosmetic____% of total practice
  ☐ Reconstruction ____% of total practice
☐ Spinal Cord Stimulators
☐ Thigh Lift
☐ Tubal Ligations
☐ Upper GI Endoscopy
☐ Vasectomies – own patients
☐ Vasectomies – own & other than own patients
☐ Weight Control Medication
____ % of total practice
☐ Other Medical Techniques, List Procedures (do not restate the applicant's specialty): _____
_____
_____
_____
_____
_____

III. PRACTICE INFORMATION (continued)

M. In the last 10 years,

1. Has the applicant discontinued major surgical procedures, performance of obstetrics, or any other medical activity? ☐Yes ☐No

   If Yes, list procedures/activities, reason for discontinuing, and date discontinued: ___/____ MM YYYY

   _____

   _____

2. Has the applicant performed weight control surgery or prescribed weight control medication? ☐Yes ☐No
   a. If Yes, what percentage of the applicant's practice (% of patient care) was devoted to prescribing anorectic drugs?
      ☐ <1% ☐ 1% - 10% ☐ 11% - 50% ☐ >50% ☐ Never prescribed weight control medication
   b. If Yes, what percentage of the applicant's practice (% of patient care) was devoted to performing weight control surgery?
      ☐ <1% ☐ 1% - 10% ☐ 11% - 50% ☐ >50% ☐ Never prescribed weight control surgery

N. Does the applicant work in an emergency room on a scheduled basis? (If Yes, answer 1 and 2 below.) ☐Yes ☐No

1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.) _____ hrs
2. On average how many of the above hours is the applicant working in order to fulfill staff privilege requirements? _____ hrs
   (If the applicant has emergency room activities which are covered by another professional liability insurance policy, please complete Question F of the Additional Professional Information section.)

O. Please use the space below for any comments the applicant feels will help the Company better understand any special circumstances concerning the applicant's practice:

_____

_____

_____

IV. ADDITIONAL PROFESSIONAL INFORMATION

Please fully explain any, "Yes," answer in the Supplemental Information section with a reference to the question. (For questions A through E. please complete Question F, if the applicant is covered by other insurance for these activities.)

A. Indicate the percentage of the applicant's practice devoted to being a team physician for any professional or collegiate athletes. ____% ☐ None

B. Indicate the average hours per week devoted to treating non-federal prison inmates. ____hrs ☐ None

C. Indicate the percentage of the applicant's practice devoted to working in a nursing home facility. ____% ☐ None

D. Does the applicant participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? ☐Yes ☐No

If Yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

E. Does the applicant practice as a medical director? ☐Yes ☐No

Type and name of facility: _____

If Yes, what percentage of the applicant's practice is devoted to this activity? _____ %

Briefly describe the applicant's responsibilities: _____

F. Does the applicant devise or review plant/employer safety standards? ☐Yes ☐No

What products are manufactured by the company? _____

Company Name: _____

Location: _____

G. Will the applicant be performing activities which will be covered by another professional liability policy? ☐Yes ☐No

If Yes, is the applicant a(n): ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

H. Has the applicant ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had the applicant's hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked suspended, restricted, subject or a reprimand, placed on probation or voluntarily surrendered? ☐Yes ☐No

If Yes, please indicate the date(s) and explain: ___/____ MM YYYY _____

I. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed the applicant's coverage or has the applicant ever had an involuntary deductible or surcharge assessed against the applicant's policy? ☐Yes ☐No

If Yes, please indicate the date(s) and explain: ___/____ MM YYYY _____

IV. ADDITIONAL PROFESSIONAL INFORMATION

J. Has the applicant ever been accused of sexual misconduct of any kind? ☐Yes ☐No

If Yes, please indicate the date(s) and explain: ___/___ MM YYYY _____

K. Has the applicant ever incurred or become aware of having a condition that impairs the applicant's ability to practice the applicant's medical specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.) ☐Yes ☐No

If Yes, state condition(s) and date(s) and identify the applicant's treating physician(s) in the space below. In the event of any such impairment, **a statement from the applicant's physician attesting to the applicant's fitness to practice the applicant's specialty must accompany this application.**

Type(s) of illness: _____

_____

Date(s) of treatment(s): From: ___/___/____ MM DD YYYY To: ___/___/____ MM DD YYYY ☐ Currently in treatment

Name of treating physician(s): _____

Address(es): _____

_____

V. LOSS INFORMATION (Important! Please fully complete.)

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.
For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against the applicant even if the applicant believes the claim or suit would be without merit.

A. Is the applicant now, or has the applicant ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?

If Yes, how many? _____ ☐ None

B. Is the applicant aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against the applicant? This includes but is not limited to, the following:
Amputation, Death, Loss of major organ function, Loss of vision, Permanent neurological injury.

If Yes, how many? _____ ☐ None

C. In the last 12 months, has the applicant or anyone from the applicant's practice received a written request from an attorney for treatment records concerning any of the applicant's current or former patients that might reasonably result in a claim or suit against the applicant?

If Yes, how many? _____ ☐ None

Please complete the questions below for all of the applicant's **(1) Open and; (2) Closed Claims.** All claims must be first dollar/ground up, and if possible, sent electronically. Only provide the claims information on those claims that are not being handled directly by the Company.

Note: Additional documentation (office/hospital records) may be requested at the underwriting department's discretion. All fields must be completed.

D. Claim Number: _____

E. Patient/Claimant Name: _____ **Age:** _____
Last Name, First Name

F. Date of treatment and/or surgery which led to the allegations against the applicant: ___ ____ MM YYYY

G. Date claim/incident notice received: ___ ____ MM YYYY

H. Has this claim/incident been reported to the applicant's current or former insurer? ☐Yes ☐No
If Yes, provide the date the claim was reported to the applicant's current or former insurer: ___ ____ MM YYYY
Please provide a copy of the report(s).

I. Name of doctor(s), health care provider(s), or other hospital(s), if any, involved in the claim or suit: _____

_____

J. Defending insurance carrier name:

_____

K. Was a claim made or suit filed? ☐Yes ☐No

L. Indicate case value established by carrier, if known: $ _____

M. Disposition or current status of claim or suit: ☐ Open ☐ Closed

If closed, date of closing/settlement or award: ___ ____ MM YYYY

If closed, was payment made? ☐Yes ☐No

If No, was claim or suit withdrawn? ☐Yes ☐No

If Yes, indicate total amount of settlement or award: $ _____

Was the matter closed with the applicant's consent? ☐Yes ☐No

If Open, has settlement been offered? ☐Yes ☐No

If Open, has trial date been set? ☐Yes ☐No

Trial date: ___ ____ MM YYYY

V. LOSS INFORMATION (Important! Please fully complete.) (continued)

N. Nature of allegations in the claim or suit:

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

O. Please provide a narrative description of the medical facts: (must include, but not limited to, the type of treatment and/or surgery, including applicant's involvement). If additional space is needed, please attach a separate piece of paper.

_____

_____

_____

_____

_____

_____

VI. COVERAGE INFORMATION

Notes:

Requested limits and/or policy types may not be available in all states.

A. Requested coverage period (12:01 am): From: ___/___/_____ To: ___/___/_____
MM DD YYYY MM DD YYYY

B. The retroactive date shown on the applicant's current Claims-Made policy is:
(This date is required for Occurrence with Prior Acts or Claims-Made with Prior Acts.) ___/___/_____
MM DD YYYY

C. Desired limits: Per Occurrence/Per Claim Filed: _____ Annual Aggregate: _____

D. List all previous professional liability insurers within the past 10 years. If the applicant's requested retroactive date is greater than 10 years, provide previous insurers back to the applicant's requested retroactive date.

1. Current Insurer: _____

☐ Occurrence ☐ Claims-Made From: ___/___/_____ To: ___/___/_____
MM DD YYYY MM DD YYYY

2. Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: ___/___/_____ To: ___/___/_____
MM DD YYYY MM DD YYYY

3. Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: ___/___/_____ To: ___/___/_____
MM DD YYYY MM DD YYYY

E. Please explain any gaps in coverage within the past 10 years. If the applicant's requested retroactive is greater than 10 years, please explain any gaps back to the applicant's requested retroactive date.

_____

_____

_____

VII. IMPORTANT NOTICE

This insurance may contain claims-made and reported coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date and reported to the Company during the policy period or during any applicable extended reporting period. Please read and review the policy carefully.

VIII. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

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, WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

_____
INITIAL HERE

VIII. FRAUD NOTICE (continued)

MANDATORY: ALL <u>ARKANSAS</u> APPLICANTS MUST READ AND INITIAL THE FOLLOWING:
ANY PERSON WHO KNOWLINGLY 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. _____ INITIAL HERE

MANDATORY: ALL <u>MAINE</u> APPLICANTS MUST READ AND INITIAL THE FOLLOWING:
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. _____ INITIAL HERE

MANDATORY: ALL <u>NEW JERSEY</u> APPLICANTS MUST READ AND INITIAL THE FOLLOWING:
ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES. _____ INITIAL HERE

MANDATORY: ALL <u>OHIO</u> APPLICANTS MUST READ AND INITIAL THE FOLLOWING:
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. _____ INITIAL HERE

MANDATORY: ALL <u>OKLAHOMA</u> APPLICANTS MUST READ AND INITIAL THE FOLLOWING:
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. _____ INITIAL HERE

IX. STATE SPECIFIC NOTICES

<u>If Arkansas</u>: This coverage is limited to claims first made and reported to the Company during the policy period as stated in the Declarations or any applicable Extended Reporting Period.

X. PLEASE READ AND SIGN

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on his, her or the facility/entity's behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that neither I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

Signature of Officer or Authorized Representative	Title	Date

XI. SUPPLEMENTAL INFORMATION