

**TO EXPEDITE THE UNDERWRITING PROCESS
PLEASE SUBMIT THE FOLLOWING WITH YOUR APPLICATION**

1. Copy of the declaration page from your current carrier.
2. Loss Runs/Claim History reports from your Current and Prior insurance carriers for the past 10 years.
3. If applicable, provide evidence of any Tail Coverage that has been purchased.
4. If you have had a claim, documentation regarding the claim(s) should be included.
5. Your Curriculum Vitae (Name, Experience, Education, etc.)
6. If you have been unemployed for any significant period please provide a statement explaining why. Include the required licensing renewal continuing education courses taken during that period.
7. Sample of your Letterhead if applicable.
8. If incorporated, provide Articles of Incorporation and Stock Ownership Certificates.
9. Copy of any Advertisements (i.e., Yellow Page, Brochures, Flyers, Business cards, etc.)
10. Website address if applicable.
11. If you are applying for Part-Time status, practicing 20 hours or less per week (including paperwork), please complete the Part-Time Status Questionnaire.

Please note, ALL the above information is needed prior to submitting your application for a quote.



APPLICATION FOR CLAIMS MADE AND REPORTED POLICY FORM FOR PHYSICIANS AND SURGEONS AND ORAL/MAXILLOFACIAL SURGEONS

- SCPIE Indemnity Company
American Healthcare Indemnity Company
American Healthcare Specialty Insurance Company

IMPORTANT PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION

INSTRUCTIONS:

SIGNATURE

Your signature and the date are required on Page 14. You must answer each question. INCOMPLETE APPLICATIONS MAY BE SUBJECT TO DECLINATION.

A COPY OF THE PHYSICIAN'S MOST RECENT DECLARATIONS PAGE FROM THE PRESENT CARRIER AND CURRENTLY VALUED LOSS RUNS MUST BE ATTACHED.

CLAIMS INFORMATION

If you have any claims, suits, or incidents alleging malpractice brought against you within the past ten (10) years, COMPLETE A CLAIM INFORMATION SHEET FOR EACH CLAIM, PAGE 12. Claims will be reviewed by Underwriting. Please provide sufficient information for the underwriters to evaluate the medical aspects of the case, specifically relating to the treatment which you rendered. Each Claim Information sheet completed must be signed and dated.

PROFESSIONAL MEDICAL/DENTAL PARTNERSHIPS OR CORPORATIONS WITH MORE THAN ONE PARTNER/SHAREHOLDER

If you are practicing in a professional medical/dental partnership or corporation with more than one partner/shareholder, it will be necessary for the entity to complete an application for coverage. Please contact your SCPIE Companies agent to obtain this form.

IT IS THE POLICY OF THE SCPIE COMPANIES NOT TO PROVIDE INSURANCE COVERAGE TO ANY PHYSICIAN WHOSE PRIMARY PRACTICE IS ASSOCIATED WITH ONE OR MORE ADDITIONAL PHYSICIANS AS AN EMPLOYEE, A PARTNER, OR A SHAREHOLDER UNLESS ALL SUCH PHYSICIANS ARE INSURED BY THE SCPIE COMPANIES.

EFFECTIVE DATE

Your application is subject to underwriting review and approval by The SCPIE Companies. The effective date of this coverage is subject to approval by The SCPIE Companies, in no event will coverage be effective prior to the date this application was received and date-stamped by The SCPIE Companies. If the application is hand-carried, received by facsimile or sent electronically, the effective date of coverage will be no earlier than the following day.

RETROACTIVE ("NOSE") COVERAGE

"Nose" coverage provides coverage for claims first made against the physician after the effective date of coverage with The SCPIE Companies, arising out of the physician's acts or omissions prior to the effective date and after the retroactive date of such coverage. If the physician does not obtain "Nose" coverage, the physician will have no coverage from The SCPIE Companies for such claims arising out of these acts or omissions. "Nose" coverage is subject to underwriting approval.

The Applicant understands that, unless he/she obtains retroactive "Nose" coverage from the Company, the policy does not provide coverage for claims reported to the Company during the coverage period relating to or arising out of incidents occurring prior to the effective date of the coverage. THIS INSURANCE IS AVAILABLE ONLY TO LICENSED PHYSICIANS AND SURGEONS.

AGENCY/BROKERAGE INFORMATION
Agency/Brokerage Name
Agent/Broker Name
Agent/Broker License No. E-Mail Address
Address
City State Zip
Phone No. () Fax No. ()

THE SCPIE COMPANIES
APPLICATION FOR CLAIMS MADE AND REPORTED POLICY FORM
FOR PHYSICIANS AND SURGEONS

OFFICE USE ONLY

Account No. _____ Policy No. _____ Group No. _____

DATE RECEIVED _____

SECTION I — GENERAL INFORMATION

1. PERSONAL INFORMATION

a. Name _____

b. Residence Address _____

City _____ State _____ Zip _____

c. Phone Number (_____) _____ Fax Number (_____) _____

d. E-Mail Address _____

e. Does the Applicant operate a website? Yes No

IF YES, SITE ADDRESS _____

f. Taxpayer I.D. / Soc. Sec. # _____ Date of Birth ____/____/____ Sex M F

g. Mailing/Billing Address _____

City _____ State _____ Zip _____

h. Phone Number (_____) _____ Fax Number (_____) _____

i. Are you a County Medical Association, Society, CALAOMS or Osteopathic Society Member? Yes No

IF YES, PLEASE NAME THE ORGANIZATION(S) _____

2. MEMBERSHIP, LICENSES AND AFFILIATION INFORMATION

a. Medical License Number _____ State _____ Expiration Date ____/____/____

b. Drug Enforcement Agency License Number _____

c. I am Board Eligible Certified Date Eligibility Expires or Date Certified ____/____/____

d. Names of American Specialty Board(s), including eligibility _____

e. List any Subspecialties _____

SECTION II — COVERAGE INFORMATION

DESIRED EFFECTIVE DATE ____/____/____

Note: The effective date of this coverage is the earliest date this application was received and date-stamped by the Company. If the application is hand-carried or received by facsimile or other electronic means, the earliest effective date of coverage is the following day. All effective dates are subject to underwriting approval.

LIMITS REQUESTED: \$ _____ Each Claim/\$ _____ Aggregate Per Policy Period

3. RETROACTIVE (“NOSE”) COVERAGE

Retroactive (“Nose”) coverage provides protection for claims first made against you after the effective date of coverage with the Company arising out of your acts or omissions prior to the effective date and after the retroactive date of such coverage. If you do not obtain “Nose” coverage, you will have no coverage from the Company for claims arising out of these acts or omissions.

THE COMPANY MAY NOT PROVIDE RETROACTIVE (“NOSE”) COVERAGE TO PHYSICIANS WHOSE PRIOR PRACTICES WERE LOCATED IN OTHER STATES.

- a. I am applying for retroactive (“Nose”) coverage: Yes No
- b. Retroactive date requested ____/____/____

I have been continuously insured with claims made coverage since this date. ____/____/____

4. PREVIOUS CARRIERS

- a. List the name(s), policy number(s), and policy period(s) for all previous professional liability insurance carriers:

| | INSURANCE CARRIER(S) | POLICY NUMBER(S) | POLICY PERIOD(S) | |
|------|----------------------|------------------|----------------------------------|----------------------------------|
| | | | From | To |
| i. | _____ | _____ | ____/____/____ Month/Day/Year | ____/____/____ Month/Day/Year |
| ii. | _____ | _____ | ____/____/____ Month/Day/Year | ____/____/____ Month/Day/Year |
| iii. | _____ | _____ | ____/____/____ Month/Day/Year | ____/____/____ Month/Day/Year |

ATTACH CURRENTLY VALUED LOSS RUNS FROM EACH CARRIER LISTED ABOVE. ALSO ATTACH A COPY OF YOUR MOST RECENT DECLARATIONS PAGE FROM YOUR PRESENT CARRIER.

- b. List all your medical specialty classifications while insured with each of the above previous claims made insurance carriers. IF YOU CHANGED MEDICAL SPECIALTIES WHILE INSURED WITH THE SAME CARRIER, LIST EACH MEDICAL SPECIALTY AND THE EFFECTIVE DATE OF EACH CHANGE. THIS IS TO ENABLE THE COMPANY TO CLASSIFY AND RATE YOU PROPERLY FOR YOUR PRIOR ACTS EXPOSURE.

| | MEDICAL SPECIALTIES | INSURANCE CARRIER(S) | POLICY PERIOD(S) | |
|------|---------------------|----------------------|----------------------------------|----------------------------------|
| | | | From | To |
| i. | _____ | _____ | ____/____/____ Month/Day/Year | ____/____/____ Month/Day/Year |
| ii. | _____ | _____ | ____/____/____ Month/Day/Year | ____/____/____ Month/Day/Year |
| iii. | _____ | _____ | ____/____/____ Month/Day/Year | ____/____/____ Month/Day/Year |

5. How did you become aware of the Company?

- Medical Association/Society Physician Colleague Mailing
 Advertisement Presentation by a Company Representative Company Website
 Other _____

6. My decision to apply to the Company was primarily based on:

- Reputation of Company Premium Considerations Coverage Quality
 Special Features Joining a Company Insured Group
 Other _____

SECTION III — MEDICAL SPECIALTIES INFORMATION

- | | |
|--|--|
| <input type="checkbox"/> Administrative Medicine | <input type="checkbox"/> Nephrology |
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Neurological Surgery |
| <input type="checkbox"/> Anesthesiology (Pain Management Only) | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> Aviation Medicine | <input type="checkbox"/> Nurse Anesthetist ¹ |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Nurse Midwife ² |
| <input type="checkbox"/> Child Psychiatry | <input type="checkbox"/> Obstetrics & Gynecology |
| <input type="checkbox"/> Colon-Rectal Surgery | <input type="checkbox"/> Occupational Medicine |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Orthopedic Surgery |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Oral/Maxillofacial Surgery |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Otolaryngology |
| <input type="checkbox"/> Family Practice (Office Surgery & Assist Only) | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Family Practice (Major Surgery - Excluding OB) | <input type="checkbox"/> Pediatric Allergy |
| <input type="checkbox"/> Family Practice (Major Surgery - Including OB) | <input type="checkbox"/> Pediatric Cardiology |
| <input type="checkbox"/> Forensic Pathology | <input type="checkbox"/> Pediatrics (General) |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> General Practice (Office Surgery & Assist Only) | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> General Practice (Major Surgery - Excluding OB) | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> General Practice (Major Surgery - Including OB) | <input type="checkbox"/> Proctology |
| <input type="checkbox"/> General Preventative Medicine | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Gynecology Only | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Hand Surgery Only | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Thoracic Surgery (No Cardiovascular) |
| <input type="checkbox"/> Hospitalist | <input type="checkbox"/> Thoracic Surgery (Including Cardiovascular) |
| <input type="checkbox"/> Industrial Medicine | <input type="checkbox"/> Undersea Medicine |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Urgent Care |
| <input type="checkbox"/> Medical Genetics - No Amniocentesis | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Neonatology | <input type="checkbox"/> Other _____ |

¹ MUST BE A SALARIED EMPLOYEE OF AN ANESTHESIOLOGIST INSURED BY THE COMPANY.

² MUST BE A SALARIED EMPLOYEE OF AN OBSTETRICIAN INSURED BY THE COMPANY.

7. Do you perform any of the following procedures or use any of the agents listed below?

PLEASE ANSWER EVERY ITEM AND, IF NECESSARY, PROVIDE EXPLANATIONS IN THE REMARKS SECTION, PAGE 11.

- | | | | |
|--|--|--|--|
| a. Hospital Surgery as Primary Surgeon | <input type="checkbox"/> Yes <input type="checkbox"/> No | l. Laser Refractive Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Assisting in Surgery Only | <input type="checkbox"/> Yes <input type="checkbox"/> No | m. Blepharopigmentation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Office Surgery ¹ | <input type="checkbox"/> Yes <input type="checkbox"/> No | n. X-Ray | |
| d. Surgery in Surgicenter ¹ | <input type="checkbox"/> Yes <input type="checkbox"/> No | i. Diagnostic | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Obstetrics | <input type="checkbox"/> Yes <input type="checkbox"/> No | ii. Therapeutic Radiation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Therapeutic Abortions | <input type="checkbox"/> Yes <input type="checkbox"/> No | iii. Ultrasound | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Number performed monthly _____ | | o. Coronary Angiography | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Amniocentesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | p. Cerebral Angiography | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Cosmetic/Plastic Surgery | | q. Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Minor ¹ | <input type="checkbox"/> Yes <input type="checkbox"/> No | r. Electroconvulsive Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ii. Major ¹ | <input type="checkbox"/> Yes <input type="checkbox"/> No | s. Endoscopy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| iii. Chemical Peels ¹ | <input type="checkbox"/> Yes <input type="checkbox"/> No | t. Sigmoidoscopy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| iv. Hair Transplants | <input type="checkbox"/> Yes <input type="checkbox"/> No | u. Spinal Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| v. Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | v. Weight Control | |
| vi. Scar Revisions | <input type="checkbox"/> Yes <input type="checkbox"/> No | i. Surgery ¹ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| vii. Sclerotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | ii. Drugs - List Below | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| viii. Silicone Injections | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |
| ix. Suction Lipectomy ^{1 & 2} | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |
| i. Fracture Reductions | | iii. Percentage of Practice _____ % | |
| i. Open | <input type="checkbox"/> Yes <input type="checkbox"/> No | w. Laser Procedures ^{1 & 2} | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ii. Closed | <input type="checkbox"/> Yes <input type="checkbox"/> No | x. Botox injections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Cardiac Catheterization | | If Yes, who performs them? <input type="checkbox"/> You <input type="checkbox"/> Other | |
| i. Right Heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | If Other, provide designation _____ | |
| ii. Left Heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | Est. number performed per year _____ | |
| k. Anesthesia | | y. Chelation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. General | <input type="checkbox"/> Yes <input type="checkbox"/> No | Est. number performed per year _____ | |
| ii. Nerve Block | <input type="checkbox"/> Yes <input type="checkbox"/> No | z. Other ¹ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| iii. Spinal/Caudal | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| iv. Local | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

¹ PLEASE EXPLAIN (USE REMARKS SECTION, PAGE 11, FOR MORE DETAIL).
² ATTACH PROOF OF TRAINING.

8. Do you practice as a hospitalist? Yes No
- a. If Yes, is there documented communication between the hospitalist and the attending/primary care physician? Yes No
 IF NO, PROVIDE EXPLANATION IN THE REMARKS SECTION, PAGE 11.
- b. Does the hospitalist cover ER or do on-call for ER? Yes No
 IF YES, PROVIDE EXPLANATION IN THE REMARKS SECTION, PAGE 11.
9. Do you currently or have you ever performed radial keratotomy? Yes No
 IF YOU NO LONGER PERFORM RADIAL KERATOTOMY, WHEN DID YOU LAST PERFORM THIS PROCEDURE? ____/____/____
10. Do you research, use, administer, or prescribe any drug, pharmaceutical or medical device disapproved or not yet approved for marketing by the United States Food and Drug Administration for treatment of human beings (including any FDA approved studies/investigations)? Yes No
 IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 11.

11. Do you provide any direct patient treatment during child delivery (including the immediate labor, puerperium, and/or neonatal period) at a facility other than a licensed acute care hospital? Yes No
12. Do you render emergency room care OTHER THAN TO YOUR OWN PATIENTS? Yes No
 IF YES, ANSWER THE FOLLOWING:
- a. Approximate number of hours per week _____
- b. A requirement for staff privileges Yes No
- c. On a fee basis Yes No
- d. On a salary basis Yes No
- e. As a member of an independent emergency room unit Yes No
- f. Name of Unit _____
- g. Do you have professional liability insurance for your Emergency Room Practice? Yes No
 IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 11.

GENERAL ANESTHESIA INFORMATION (ORAL/MAXILLOFACIAL SURGEONS ONLY)

13. Do you use or have:
- a. Oral/Maxillofacial Anesthesia Permit No. _____ State _____ Expiration Date ___/___/___
- b. Continual blood pressure monitoring either by use of an intra-arterial and electronic monitor or standard blood pressure cuff with checks at appropriate intervals Yes No
- c. Continuous electrocardiographic display Yes No
- d. Continuous peripheral blood flow monitoring (Pulse Monitor) Yes No
- e. Precordial, esophageal, or retracheal stethoscope Yes No
- f. Pulse Oximeter Yes No
- g. End-Tidal CO₂ or Capnometer Yes No
- h. Any other devices (explain) _____

NOTE: COVERAGE IS DEPENDANT UPON EMPLOYMENT OF EITHER DEVICE b. OR c. AND TWO OF DEVICES d. THROUGH g.

SECTION IV — PRACTICE LOCATION INFORMATION

INSTRUCTIONS FOR SECTION IV - PRACTICE LOCATION INFORMATION

This section describes where you practice and the relationships you have in your practice with others (if any). We have referred to the others with whom you practice “organizations”, but the term “organizations” could refer to individuals as well (see further examples in the “Explanation of Question 15a.” below).

Where requested, please also provide information regarding the Professional Liability Insurance that pertains to both you and those “organizations” with whom you practice. Note that not all of these questions will apply to all relationships.

If you practice at a location for which insurance coverage is provided by another company, please provide such information for that practice and clearly indicate that coverage with SCPIE/AHI is not desired at that location.

14. Do you practice (provide patient care) at more than one location? Yes No
- a. No. of locations _____
- b. IF YOU PRACTICE AT MORE THAN ONE LOCATION, PLEASE COPY AND COMPLETE PAGE 7 FOR EACH PRACTICE LOCATION.

Explanation of Question 15a.: List the name of the “organization” for which you practice:

| | | | |
|---------------------------|---------------|----------------------------|----------------------|
| • Your name | • Group | • Clinic | • County/University |
| • Your DBA (if any) | • Partnership | • Public or Private Entity | • Federal Government |
| • Another Physician’s DBA | • Corporation | • HMO | • State Government |

Explanation of Question 15f.: Not applicable to those physicians in solo practice. Information on the Professional Liability Insurance that the “organization” carries, whether it provides coverage for you or not.

15. PRACTICE LOCATION

Coverage with SCPIE/AHI at this location desired? Yes No

a. Name of the Practice _____
 Administrator's Name (if any) _____
 Address _____
 City _____ State _____ Zip _____
 Phone (_____) _____ Fax (_____) _____

b. Number of hours per week you provide services for this practice _____

c. Estimated number of patients seen weekly at above location _____

d. Do you own, lease or rent this location? Yes No _____ Sq. Ft.

e. **YOUR** Professional Liability Carrier at the location indicated above.

Name _____

f. Professional Liability Carrier for "**ORGANIZATION**" indicated above.

Name _____

Are you covered by the "organization's" professional liability policy? Yes No

If Yes, will coverage be maintained for you separate from the policy for which you are applying? Yes No

g. Do you employ or retain any physicians Yes No ; OR
 are you employed or retained by another physician at this location? Yes No

His/Her Name _____ Carrier _____ Contracting Relationship
 Employment Relationship

His/Her Name _____ Carrier _____ Contracting Relationship
 Employment Relationship

h. Indicate the names of individuals who provide the following services in your office and indicate whether they are salaried employees or independent contractors. If none, check "NONE". NONE

LIST ADDITIONAL EMPLOYEES IN REMARKS SECTION, PAGE 11.

| | | | |
|-----------------------------|-----------------------|--------------------------------------|--|
| ___ Acupuncturist | ___ Dietitian | ___ Optometrist | ___ Podiatrist |
| ___ Certified Nurse Midwife | ___ Licensed Midwife | ___ Perfusionist | ___ Psychological Assistant ¹ |
| ___ Chiropractor | ___ Nurse Anesthetist | ___ Pharmacist | ___ Psychologist ¹ |
| ___ Dentist | ___ Optician | ___ Physician Assistant ¹ | ___ Registered Nurse Practitioner ¹ |

| Name | Title | Salaried Employee | Independent Contractor |
|-------|-------|--------------------------|--------------------------|
| _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

¹ PLEASE ATTACH A COPY OF THEIR LICENSE.

i. Indicate the number of the following types of other individuals who provide services at this location:
 If none, check "NONE". NONE

| | | |
|------------------------------|--------------------------------------|-----------------------------------|
| ___ Audiologist | ___ Nurse (Registered or Vocational) | ___ Technician (Lab, Pathologist) |
| ___ Clerical | ___ Physical Therapist | ___ Technician (X-Ray, Radium) |
| ___ Dental Hygienist | ___ Respiratory Therapist | ___ Other (please describe) |
| ___ Hearing Aid Dispensers | ___ Social Worker | _____ |
| ___ Medical/Dental Assistant | ___ Speech Pathologist | _____ |

NOTE: CERTAIN EMPLOYEES OF QUESTIONS h. AND i. ARE NOT COVERED UNLESS SPECIFICALLY APPROVED AND ENDORSED BY THE COMPANY. ALSO, INDEPENDENTLY CONTRACTED EMPLOYEES MAY BE REQUIRED TO OBTAIN SEPARATE PROFESSIONAL LIABILITY INSURANCE COVERAGE.

Please indicate your relationship to this practice location.
 (Check all that apply)

Individual Practitioner
 Solo Medical Corporations
 Independent Contractor
 Salaried Employee
 Officer/Director/Shareholder of Medical Corp (Not Solo)
List Owners in Remarks Section

Partner in a Medical Partnership
List Owners in Remarks Section

Other, please describe:

SECTION V — OTHER PROFESSIONAL DUTIES

16. Are you (1) a partner, shareholder, owner, proprietor, superintendent, administrative or executive officer or medical director of any hospital, sanitarium, medical or other clinic, clinic with bed and board facilities, skilled nursing facility, convalescent hospital, surgical center, laboratory, health maintenance organization, preferred provider organization, exclusive provider organization or similar health care provider, or (2) a member of a peer review or other committee of any of the entities or organizations named in clause (1)? Yes No

IF YES, DESCRIBE ACTIVITIES IN REMARKS SECTION, PAGE 11.

17. Do you see patients in any skilled nursing facility, convalescent hospital, nursing home or similar facility? Yes No
 If YES, are you employed contracted medical director

| Name of Facility | City | No. of Hours Worked Per Week | No. of Patients Seen Per Week |
|------------------|-------|------------------------------|-------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

18. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunications, video, or information systems? Yes No
 IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 11.

a. If you provide telemedicine services, are any slides, specimens, x-rays, etc. sent from a state other than the state in which you maintain the office location(s) identified in this application? Yes No
 IF YES, PLEASE IDENTIFY ALL OF THE STATES: _____

19. Are you an owner or do you have ownership interest in a blood bank, laboratory, or hemodialysis unit? Yes No
 IF YES, COMPLETE THE FOLLOWING:

a. Name and address of the facility _____

b. Designate the exact capacity in which you serve (e.g., owner in whole or part, executive officer, administrator, departmental or ancillary service supervisor or physician with teaching responsibilities).

c. Do you have professional liability coverage for this practice? Yes No
 IF YES, WHAT IS THE NAME OF YOUR INSURANCE CARRIER? _____

d. Number of hours per week in this capacity _____

20. Are you employed by a state, federal or local public entity? Yes No
 IF YES, PLEASE COMPLETE SECTION IV WITH REGARD TO THAT PRACTICE.

21. If the total hours of practice described in the previous page (7) equal less than 20 hours, how is the remainder of your professional time spent? _____

SECTION VI — MEDICAL EDUCATION AND PRACTICE INFORMATION

22.

a. Medical School _____

 City State

 City State

 City State

b. Internship _____

 City State

 City State

c. Residency I _____

 City State

 City State

d. Residency II _____

 City State

 City State

e. Fellowship _____

 City State

 City State

23. I have practiced at the following locations during the past ten (10) years (not including training).

a. _____
 Name of Practice _____

 Type of Practice (i.e., Medical Group, HMO) Address City State

b. _____
 Name of Practice _____

 Type of Practice (i.e., Medical Group, HMO) Address City State

LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 11.

24. Are you a solo physician? Yes No
 IF YES, PLEASE PROVIDE NAMES OF YOUR DBA'S OR NAME OF YOUR CORPORATION, IF ANY. ATTACH COPIES OF FICTITIOUS NAME PERMITS AND/OR ARTICLES OF INCORPORATION.

SECTION VII — UNDERWRITING INFORMATION

25. Has any insurance company canceled, declined coverage or modified (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any professional liability insurance? Yes No
 IF YES, DESCRIBE IN REMARKS SECTION (PAGE 11) AND INCLUDE COMPANY NAME AND POLICY NUMBER.

26. Have you ever been investigated by any Dept. of Professional Regulations, State Medical Board of Examiners and/or Board of Dental Examiners, the State Licensing Authority, Osteopathy Board, Narcotics Bureau or other governmental agency? Yes No

IF YES, DESCRIBE IN REMARKS SECTION, PAGE 11.

27. Have you ever been charged with or convicted of a crime other than a minor traffic violation? Yes No

IF YES, PLEASE EXPLAIN _____

28. Has a claim, incident or suit for alleged malpractice been brought against you within the last ten (10) years? Yes No

IF YES, COMPLETE A CLAIM INFORMATION SHEET, PAGE 12, FOR EACH CLAIM.

29. Do you know of any incident(s) that might provide a basis for any claim or suit to be brought against you? Yes No

IF YES, DESCRIBE IN REMARKS SECTION, PAGE 11.

30. Has any physician, patient or insurance company ever filed a complaint of any kind against you with your medical society or foundation? Yes No

IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 11.

31. Have you ever had your hospital privileges reduced, restricted, preceptored or suspended? Yes No

IF YES, DESCRIBE THE CIRCUMSTANCES IN REMARKS SECTION, PAGE 11.

32. List hospitals to which you are applying for staff privileges, or are currently a staff member and the percentage of patient admissions for each hospital during the last twelve (12) months, including consultations.

| | |
|------------------------|------------------------|
| _____ Hospital _____ % | _____ Hospital _____ % |
| _____ Hospital _____ % | _____ Hospital _____ % |
| _____ Hospital _____ % | _____ Hospital _____ % |
| _____ Hospital _____ % | _____ Hospital _____ % |

LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 11.

33. Briefly describe the type(s) and extent of your hospital privileges: _____

34. If you do not have hospital privileges, please identify below which admitting mechanism you use:

- Hospitalists Another physician admits my patients Other
 911 No admitting mechanism PLEASE EXPLAIN IN REMARKS SECTION, PAGE 11.

35. Are you providing medical services to any professional, college, or amateur athletic team on any basis? Yes No

IF YES, DESCRIBE IN REMARKS SECTION, PAGE 11.

36. What percentage of your practice has signed patient arbitration agreements? _____ %
 What patient arbitration agreement do you use in your practice? _____

PLEASE ATTACH A COPY.

37. IMPORTANT: PLEASE PROVIDE A COPY OF YOUR LETTERHEAD, IF AVAILABLE.

SECTION X — CLAIMS INFORMATION

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED.

NOTE: Please provide sufficient information for underwriters to evaluate the medical aspects of the case especially relating to your involvement.

1. Name of Patient _____ 2. Age _____ 3. Male Female

4. Allegation _____

5. Date claim was made or filed ___/___/___ 6. Date of incident leading to allegation ___/___/___

7. Insurance company _____

8. Additional defendants _____

9. Location of occurrence _____

10. Disposition of claim OPEN CLOSED a. Exact date closed ___/___/___
b. Total settlement or judgment \$ _____
c. Amount paid on your behalf \$ _____

The following questions should be answered in adequate clinical detail to allow proper evaluation.

11. Condition and diagnosis at time of incident (**Include dates of visits**)

12. Date and description of treatment rendered (**Include dates of visits**)

13. Condition of patient subsequent to treatment (**Include dates of follow-up treatment**)

I understand information submitted herein becomes part of the Physician's Professional Liability Application as submitted.

Date ___/___/___ Signed _____

SECTION XI — SIGNATURE

THIS IS THE SIGNATURE SECTION TO THE APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE FOR ALL PHYSICIANS AND SURGEONS.

REPRESENTATIONS AND AUTHORIZATIONS OF APPLICANT

I UNDERSTAND THAT IT IS THE POLICY OF THE COMPANY GENERALLY NOT TO PROVIDE INSURANCE COVERAGE TO ANY PHYSICIAN WHO IS ASSOCIATED WITH ONE OR MORE ADDITIONAL PHYSICIANS AS A MEMBER OF A PROFESSIONAL MEDICAL/DENTAL PARTNERSHIP OR CORPORATION OR AS AN EMPLOYER OR EMPLOYEE OF SUCH PHYSICIAN, UNLESS ALL SUCH PHYSICIANS ARE INSURED BY THE COMPANY OR ARE CURRENTLY FILING APPLICATIONS FOR INSURANCE WITH THE COMPANY. I FURTHER UNDERSTAND THAT ANY INSURANCE COVERAGE PROVIDED TO ME BY THE COMPANY IS SUBJECT TO CANCELLATION IN THE EVENT ANY PHYSICIAN WITH WHOM I AM OR BECOME ASSOCIATED, AS A MEMBER OF A PROFESSIONAL ASSOCIATION, MEDICAL/DENTAL PARTNERSHIP OR CORPORATION, OR AS AN EMPLOYER OR EMPLOYEE OF SUCH PHYSICIAN, IS NOT OR CEASES TO BE AN INSURED BY THE COMPANY.

Note: The Company, in certain instances, will issue policies to individual insured physicians who are associated with physicians in a professional medical/dental partnership or corporation in which all of the other physicians are not insured by the Company or when a physician employer or employee of the insured is not insured by the Company. Physicians are cautioned that there is no coverage under such policies for acts or omissions of the physicians not insured by the Company.

I authorize the release and exchange of information involving past and future underwriting and claims matters between the Company and my present and any past professional associations/societies, the county medical association/society in any county in which I practice(d), their committees and insurance consultants, any hospital with which I presently or previously held staff privileges, any prior insurance companies and any state medical licensing board or other governmental agency. I authorize the Company to forward Evidence of Insurance to the hospitals listed in response to Question 32 and the Emergency Departments/Hospitals/Health Plans who provide my signed authorization to do so in the future.

I agree that the Company and, to the extent requested by the Company and/or any other authorized representatives of the Company, may participate in the processing and review of this application, of any future information submitted and of any matter relating to any incidents or claims of alleged medical malpractice while I am insured by the Company.

I also agree that if requested by the Company, I will promptly submit a Request for Information Disclosure form to The National Practitioner Data Bank requesting a Self-Query, and will forward the full results of such query to the Company immediately upon my receipt thereof for inclusion in this application for insurance.

If I become a physician member under a policy issued by the Company to a partnership or corporation (as "named insured"), I irrevocably authorize and designate the medical/dental partnership or medical corporation, if any, of which I am a member, officer, director or employee to act on my behalf and as my agent in all respects (including, without limitations, the payment of premiums, and the receipt of refunds thereof, and the receiving and giving of notices of all types) relating to the insurance for which I am applying. This authorization and designation shall remain in effect for so long as such partnership or corporation is a named insured under an insurance policy issued by the Company and I am a certificate holder under such policy.

I HEREBY REPRESENT THAT THE STATEMENTS AND ANSWERS MADE WITHIN THIS APPLICATION ARE FULL, COMPLETE AND TRUE. ALSO, I UNDERSTAND THAT THIS IS NOT A BINDER OF INSURANCE, BUT IS INSTEAD AN APPLICATION FOR INSURANCE, AND THAT IT IS SUBJECT TO UNDERWRITING REVIEW AND APPROVAL.

NOTE: THE FOLLOWING TWO (2) PARAGRAPHS APPLY TO SCPIE INDEMNITY COMPANY APPLICANTS ONLY.

It is the policy of SCPIE Indemnity Company that all of its insurance policies expire each year on January 1 at 12:01 a.m. and that changes in premiums and other policy terms are generally made at that time. If a policy is first issued after the first day of a calendar year, such changes in premium terms may be made at the following January 1 only if the insured requests a policy term of less than one (1) year.

APPLICANT HEREBY REQUESTS THAT SCPIE INDEMNITY COMPANY ISSUE THE POLICY FOR A TERM EXPIRING AT 12:01 A.M. ON JANUARY 1 NEXT FOLLOWING THE DATE OF THIS APPLICATION. APPLICANT UNDERSTANDS THAT PREMIUMS WILL BE PAYABLE QUARTERLY.

Notice To California Applicants

“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.”

Name of Applicant (Please type or print name)

Signature of Applicant (Please sign your name)

Address

City

State

Zip

____/____/____
Date



American Healthcare Indemnity
COMPANY

Physician's Part Time Status Questionnaire

| | | DATE RECEIVED |
|----------------------|--|---------------|
| Name: _____ | | |
| Policy Number: _____ | | |

1. Are you a full-time teaching healthcare professional? Yes No

2. Are you nearing retirement? Yes No

If yes, when do you plan to retire? _____

3. Are you recuperating from a disability? If yes, please specify extent of your disability: Yes No

4. Are you employed full-time (over 20 hours/week) elsewhere with evidence for such employment? If yes, where and how many hours are devoted to this type of employment? Yes No

5. Do you derive any income from the practice of medicine other than as above? Yes No

6. Hours worked per week (for coverage under this policy): _____

7. Number of patients seen per week: _____

8. If no to questions 1 – 5, please give the reason you are practicing on a part time basis: _____

Signature

Date Signed