

4. Are you a participant in a patient compensation fund or other similar program of state-sponsored liability insurance? (*Example: MCARE in Pennsylvania*) Yes No
5. Are you a member of a professional corporation, a professional association or a partnership that is entirely owned by healthcare providers that participates in a state-sponsored professional liability fund? **If Yes**, please explain. Yes No
6. Has your license ever been suspended or revoked?
If yes, please attach a separate sheet containing a complete explanation. Yes No
7. Have you ever been convicted of a crime?
If yes, please attach a separate sheet containing a complete explanation. Yes No
8. Prior Insurance: List your insurers on your employers' insurers the past three (3) years. Attach additional pages as needed.

Insurance Carrier	Policy Period	Limits of Liability	Coverage Type (Occurrence / Claims Made)

9. Practice Locations: List ALL locations at which you have practiced in the last five (5) years. Explain any gaps in time.

Name of Practice	City/State	From (MM/YY)	To (MM/YY)

PROFESSIONAL SERVICES PROVIDED:

1. Type of Practice:
- | | |
|-----------------|--------------------|
| Family Medicine | Emergency Medicine |
| OB /GYN | Pre-Natal Services |
| Abortions | Orthopedics |
| Cardiology | Neurology |
- Alternative Medicine
If checked, please describe:
- Surgery
If checked, please describe:
- Drug Therapy
If checked, please describe:

PROFESSIONAL SERVICES PROVIDED:

1. Hours of Practice:

- Full Time (≥ 35 hours per weeks of ALL covered professional activities and locations)
- Part-Time (< 35 hours per week or ≥ 10 of ALL covered professional activities and locations)
- Incidental (< 10 hours per week)

PRACTICE LOCATIONS:

- | | | |
|--|-----|----|
| 1. Do you serve as the Medical Director for this entity? | Yes | No |
|--|-----|----|

PRACTICE PROFILE: Please attach a separate sheet for any required explanations.

- | | | |
|---|-----|----|
| 1. Do you create and maintain medical records for each patient under your care?
If no, please explain: | Yes | No |
|---|-----|----|

- | | | |
|---|-----|----|
| 2. Do you obtain an informed consent, whether signed by patient or guardian before prescribing controlled substances? | Yes | No |
|---|-----|----|

- | | | |
|--|-----|----|
| 3. Does your practice include telemedicine activities, e.g., the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved? | Yes | No |
|--|-----|----|

a. If yes, what is the percent of your total practice time devoted to this activity?	%
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b. If yes, on a separate sheet, please explain the exact type of telemedicine.
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Declarations

REPRESENTATIONS: I/We affirm that the information contained here and in any addendum is true to the best of my/our knowledge and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We hereby authorize the release of claim information from any prior insurer to the Company or its representatives.

FRAUD NOTICE STATEMENTS

NOTICE TO 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 AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO ALASKA RESIDENTS APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

NOTICE TO ARKANSAS RESIDENT APPLICANTS: "ANY PERSON WHO KNOWINGLY 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."

NOTICE TO ARIZONA RESIDENTS APPLICANTS: "FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO COLORADO RESIDENTS APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR

ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.”

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: “WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.”

NOTICE TO FLORIDA RESIDENTS APPLICANTS: “ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.”

NOTICE TO KENTUCKY APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY “MATERIALLY” FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.”

NOTICE TO LOUISIANA RESIDENTS APPLICANTS: “ANY PERSON WHO KNOWINGLY 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.”

NOTICE TO MAINE RESIDENTS APPLICANTS: “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 OR A DENIAL OF INSURANCE BENEFITS.”

RESIDENTS OF MARYLAND APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.”

RESIDENTS OF MINNESOTA APPLICANTS: “ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.”

RESIDENTS OF NEW JERSEY APPLICANTS: “ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.”

RESIDENTS OF NEW MEXICO APPLICANTS: “ANY PERSON WHO KNOWINGLY 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 CIVIL FINES AND CRIMINAL PENALTIES.”

RESIDENTS OF NEW YORK 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 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.”

RESIDENTS OF OHIO APPLICANTS: “ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.”

RESIDENTS OF OKLAHOMA APPLICANTS: “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.”

RESIDENTS OF OREGON APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.”

RESIDENTS OF PENNSYLVANIA 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 AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF TEXAS APPLICANTS: IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF VIRGINIA APPLICANTS: "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."

RESIDENTS OF WASHINGTON APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WEST VIRGINIA APPLICANTS: "ANY PERSON WHO KNOWINGLY 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."

Physician's Name (Print/Type):

Physician's Personal Signature: _____

Date:

CLAIMS HISTORY- SUPPLEMENTAL APPLICATION

Full Name:

IMPORTANT: This section must be completed in its entirety. Any malpractice claims or suits in which you have been involved in during the past seven (7) years must be reported. Any incidents or circumstances of which you are aware, that are likely to give rise to a claim, must be reported. Provide copies of suit papers or claimant letters. If the claim is closed, provide copies of settlement or judgment documents or order of dismissal. If reporting more than one incident, suit or claim, photocopy this form for each.

N/A (Please proceed to Signature.)

1. Name of Patient:

2. Allegation/incident:

3. Incident Date:

4. Report Date:

5. Was suit filed?

Yes No

6. Jurisdiction:

7. Names of Co-Defendants:

(N/A)

8. Insurance Carrier(s) covering claim:

Policy Period(s):

9. Final outcome of claim ***(This information may be obtained by inquiry of your current or past insurer. Please note that you must personally contact your insurance carrier.)***

Open (still pending)

Indemnity reserve placed by insurer: \$
 Defense cost reserve placed by insurer: \$

Closed:

Method of Closing

Total Expenses

Dismissed
 Withdrawn
 Judgment
 Settlement

Amount of settlement of judgment: \$
 Defense cost: \$

10. Please provide summary of clinical facts. Your summary must provide an adequate description of your care and treatment of the patient to allow proper evaluation. Please include the following: (Use additional sheets if necessary.)

a. Patient age and sex:

b. Initial patient condition and diagnosis:

- c. Condition and diagnosis at time of incident:

- d. Dates and description of treatment rendered:

- e. Condition of patient subsequent to treatment:

- f. Copies of patient's records and progress notes as appropriate:

Physician's Personal Signature

Date