APPLICATION INSTRUCTIONS

ALLIED HEALTHCARE APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

In order to hasten your request for coverage and avoid any unnecessary delay, please complete all questions. If a question does not apply to your specialty, mark "None" or "N/A" (Not Applicable). Do not leave any question unanswered! Please use separate paper for any additional comments, explanation or clarification if necessary.

Before submitting your application, please review this checklist to ensure the information below has been included. Missing information could delay the approval of your application.

- q **Sign, initial and date the application where indicated. The company will not issue quotes for unsigned applications.**
- q **Include a copy of your license and current Curriculum Vitae (CV).**
- q **Include a copy of your most recent professional liability declaration page and claims history with retroactive date.**

If you need assistance with the application, please call (818) 889-7399 and ask to speak with a medical liability specialist.

NOTICE
This application s issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

ALLIED HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS
FOR PROFESSIONAL LIABILITY INSURANCE
(CLAIMS MADE BASIS)

APPLICANT INSTRUCTIONS:

1. Indicate your requested effective date of coverage: _____ / _____ / _____
2. Please type or print.
3. Answer all questions. If the answer requires detail, please attach a separate sheet.
4. Please complete application at least **30 days** before the proposed effective date.
5. **Include a copy of your license and CV.**
6. Please carefully read the statements at the end of this application.

I. PERSONAL AND PROFESSIONAL INFORMATION

1. Name _____ (LAST / FIRST / MIDDLE) q P.A. q N.P.

Other Names Used _____

2. Home Address _____ (STREET ADDRESS / CITY / STATE / ZIP)

Home Phone ( ) _____ Home Fax ( ) _____

3. Primary Office _____ (STREET ADDRESS / CITY / STATE / ZIP)

Business Phone ( ) _____ Business Fax ( ) _____

Cell ( ) _____ Pager ( ) _____ Back Office ( ) _____

4. Date of Birth / / **5. Social Security #** - - **6. Employer IRS #** _____

7. Medical License # _____ **8. E-Mail** _____

9. Website Address _____

10. Office Locations (Please list primary location above under # 3 and any secondary offices below)

a. _____ (STREET ADDRESS / CITY / STATE / ZIP / % OF PRACTICE)

b. _____ (STREET ADDRESS / CITY / STATE / ZIP / % OF PRACTICE)

II. SPECIALTY INFORMATION

1. Medical Specialty _____ **% Of Practice** _____

Are you requesting professional liability coverage for this specialty? q YES q NO

ABMS Certified? q YES q NO
Board Eligible? q YES q NO

If **Board Eligible,** when do you plan to take your exams? ORAL / / (MM DD YY) WRITTEN / / (MM DD YY)

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III. TYPE OF PRACTICE

1. **Please list the names of all physicians with whom you practice in an office setting:** _____

2. **Do you prescribe drugs or provide diagnosis via the internet?** q YES q NO

   (If **Yes**, please explain on a separate sheet)

IV. OFFICE SURGERY

1. **Do you have a full ACLS Resuscitation (crash) cart in your office?** q YES q NO
2. **Are you ACLS Certified?** q YES q NO

   If **Yes**, Expiration Date: ____/____/____
3. **Do you have an accredited surgicenter in your office?** q YES q NO

V. PRACTICE HISTORY

1. **Please list all locations where you have practiced in the last 5 years**, beginning with the most recent location first.

   a. q SOLO q EMPLOYEE

   GROUP/PRACTICE NAME | CITY | STATE | FROM (MM / YYYY) | TO (MM / YYYY) — *Present*

   b. q SOLO q EMPLOYEE

   GROUP/PRACTICE NAME | CITY | STATE | FROM (MM / YYYY) | TO (MM / YYYY)

   c. q SOLO q EMPLOYEE

   GROUP/PRACTICE NAME | CITY | STATE | FROM (MM / YYYY) | TO (MM / YYYY)

2. **Please list all hospitals where you have privileges.** (List principal locations first)

   a. HOSPITAL | ADDRESS | CITY | STATE | ZIP

   b. HOSPITAL | ADDRESS | CITY | STATE | ZIP

   c. HOSPITAL | ADDRESS | CITY | STATE | ZIP

3. **List all previous professional liability carriers for the last 5 years, beginning with your current carrier first.**
   If none, state 'None.'

INSURANCE CARRIER	LIMITS OF LIABILITY (i.e. $1M/$3M)	PREMIUM	POLICY PERIOD	
			FROM	TO
	/	$	/ /	/ /
	/	$	/ /	/ /
	/	$	/ /	/ /

4. **Please explain all gaps in coverage greater than 60 days** (use a separate sheet if necessary): _____

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VI. PROFESSIONAL HISTORY

1. **Have you ever had your hospital privileges suspended, denied, restricted, placed in probationary status or revoked?** q YES q NO

   (If **Yes**, please explain on a separate sheet)

2. **Has any governmental agency investigated, suspended, revoked, or taken any other action against your license to practice medicine?** q YES q NO

   (If **Yes**, please provide copies of complaint and disposition documents)

3. **Have you ever been charged with or convicted of a crime other than minor traffic violations?** (If **Yes**, please explain on a separate sheet) q YES q NO

4. **Have you ever been diagnosed, treated or voluntarily entered into treatment for alcoholism, drug addiction, chemical dependency or a mental or chronic physical illness?** (If **Yes**, please explain on a separate sheet) q YES q NO

5. **Has any professional liability carrier ever terminated, restricted or modified your coverage (e.g. Applied surcharges, co-payments or deductibles) or denied you professional liability coverage?** (If **Yes**, please explain on a separate sheet) q YES q NO

6. **Does your entity include a surgicenter, laboratory or other freestanding facility?** q YES q NO

VII. APPLICANT CLAIMS HISTORY

DEFINITION: A claim is a demand for money from a patient or on a patient's behalf, a 90-day notice of intention to sue, a lawsuit, a counterclaim or a demand for arbitration.

Please be advised that you will have no coverage from Fairway Physicians Insurance Company for any known claims or incidents that may lead to a claim or lawsuit. All claims or incidents that may lead to a claim or lawsuit should be reported to your current malpractice insurer before terminating your existing policy (coverage for any such lawsuits, claims or incidents is subject to the terms of your current carrier's policy).

1. **Have you ever been or are you now involved in any professional liability (malpractice) claims or lawsuits?** q YES q NO

   If **Yes**, Number of Claims: _____ If **Yes**, **Claims Information** (Sec VIII) *MUST* be completed for <u>each</u> claim.

2. **Have all claims been reported to your current or previous professional medical liability insurance carrier(s)?** q YES q NO

3. **Have you ever attempted or settled a claim on your own behalf that you did not report to a previous medical liability carrier?** q YES q NO

4. **Have you ever had any professional liability insurance declined, non-renewed or accepted malpractice insurance on special terms?** q YES q NO

   If **Yes**, please explain: _____

5. **Has any claim or suit been brought against you?** q YES q NO

   If **Yes**, the **Claims Information** *MUST* be completed for each claim or suit. Refer to Section VIII.

   If **Yes**, has this information been reported to your current or prior insurance carrier? q YES q NO

6. **Have you ever practiced without professional liability insurance?** q YES q NO

   If **Yes**, please explain and specify dates: _____

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VIII. CLAIMS INFORMATION

PLEASE COPY THIS PAGE FOR ALL ADDITIONAL CLAIMS YOU ARE REPORTING TO FAIRWAY.

NOTE: This **Claims Information Form** pertains to lawsuits, claims or demands for arbitration or incidents which could lead to claims. A claims form must be completed for each lawsuit, claim, demand for arbitration or incident. Sufficient information must be provided to evaluate the medical aspects of the case specifically relating to the physician's involvement.

1. **Patient's Name:** _____ 2. **Age:** _____ 3. **Sex (M/F):** _____

4. **Your relationship to patient**:

_____

5. **Date of Incident:** ___/___/___ 6. **Location:** _____

7. **Insurance Carrier:** _____ 8. **Other Defendants:** _____

_____

9. **Present Status:** q OPEN q CLOSED ___/___/___ _____
DATE

q INCIDENT ONLY q 90-DAY NOTICE q SUIT FILED q SUIT SERVED q ARBITRATION

Method of Closing: q DISMISSED q DEFENSE VERDICT

q SETTLED AMOUNT PAID ON YOUR BEHALF: $_____ TOTAL SETTLEMENT: $_____

q JUDGMENT AMOUNT PAID ON YOUR BEHALF: $_____ TOTAL SETTLEMENT: $_____

The following questions should be answered in explicit clinical detail to allow proper evaluation by the FAIRWAY Underwriting Department. Attach additional sheets as required.

10. **Patient's allegations or circumstances brought to your attention:** _____

_____

11. **Condition and diagnosis at time of incident:** _____

_____

_____

12. **Dates and description of treatment rendered:** _____

_____

_____

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

_____

_____

I understand information submitted herein becomes part of the FAIRWAY's Named Insured's records.

___/___/___ _____
DATE NAME (PLEASE PRINT)

_____
SIGNATURE

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IX. MEDICAL PROCEDURES INFORMATION

Fairway Physicians Insurance Company uses the following definitions to clarify proper specialty classification. Please review the definitions, then proceed to indicate which procedures you perform if any.

No Surgery – Any practitioner who does not perform obstetrical procedures or surgery (other than incision of boils and superficial abcesses, removal of superficial growths, or suturing of skin superficial fascia) and do not assist in surgery.
Minor Surgery – Any practitioner who assists in major surgery on their own patients, and performs catheterization, endoscopy (other than colonoscopy, proctocolonoscopy, or sigmoidoscopy), vasectomies, hemorrhoidectomies, diagnostic D & C's and vacuum curettage abortions during the first trimester of pregnancy.
Major Surgery – Any surgery other than "minor surgery" and assisting at major surgery on other than their own patients.

ACUPRESSURE	q YES	q NO	NON-FDA APPROVED DRUGS, PHARMACEUTICALS OR MEDICAL DEVICES	q YES	q NO
ACUPUNCTURE	q YES	q NO	HYPOTHYROIDISM	q YES	q NO
ALLERGY	q YES	q NO	IV THERAPY	q YES	q NO
ANTI-AGING	q YES	q NO	NEURAL THERAPY	q YES	q NO
ARTHRITIS TREATMENT	q YES	q NO	NUTRITIONAL THERAPY	q YES	q NO
AURICULOTHERAPY	q YES	q NO	PAIN MANAGEMENT	q YES	q NO
BARIATRICS	q YES	q NO	PROLOTHERAPY	q YES	q NO
BIO-IDENTICAL HORMONAL THERAPY	q YES	q NO	RHEUMATOLOGY	q YES	q NO
BIO-OXIDATIVE THERAPIES	q YES	q NO	THERMOGRAPHY	q YES	q NO
CANDIDIASIS	q YES	q NO	ULTRAVIOLET LIGHT BLOOD IRRADIATION	q YES	q NO
CHELATION THERAPY	q YES	q NO	WEIGHT MANAGEMENT	q YES	q NO
CHEMICAL SENSITIVITY	q YES	q NO	TEACHING	q YES	q NO
COLON HYDROTHERAPY	q YES	q NO		q YES	q NO

ANESTHESIA (Pain Management Only)	q YES	q NO	NURSING HOME/ASSISTED LIVING CARE	q YES	q NO
ARTERIOGRAPHY	q YES	q NO	PHYSICAL MEDICINE & REHABILITATION (No Procedures)	q YES	q NO
BARIATRIC SURGERY	q YES	q NO	PHYSICAL MEDICINE & REHABILITATION (Minor Procedures)	q YES	q NO
BOTOX	q YES	q NO	PHYSICAL MEDICINE & REHABILITATION (Major Procedures)	q YES	q NO
CARDIAC CATHETERIZATION	q YES	q NO	PLASTIC SURGERY	q YES	q NO
CONVULSIVE SHOCK THERAPY	q YES	q NO	SKIN RADIATION TREATMENT	q YES	q NO
CORONARY ARTERIOGRAPHY	q YES	q NO	SURGICAL ASSIST (On Own Patients)	q YES	q NO
CORONARY ANGIOPLASTY	q YES	q NO	SURGICAL ASSIST (On Other Patients)	q YES	q NO
COSMETIC PROCEDURES & SURGERY (Please describe below)	q YES	q NO	LIPO SUCTION _____%	q YES	q NO
DERMABRASION	q YES	q NO	URGENT CARE	q YES	q NO
EMERGENCY ROOM DUTIES	q YES	q NO	NO SURGERY	q YES	q NO
LAMINECTOMY	q YES	q NO	MINOR SURGERY	q YES	q NO
OBSTETRICS	q YES	q NO	MAJOR SURGERY	q YES	q NO

Please describe all Cosmetic Procedures & Surgery:

_____

_____

_____

Please describe any procedures done outside office setting (ie: Botox parties):

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X. APPLICANT RETROACTIVE COVERAGE

The following questions refer to your application for retroactive coverage (i.e. "Prior Acts" or "Nose Coverage") with Fairway Physicians Insurance Company ("FAIRWAY").

If you are approved for retroactive coverage, you will receive a certificate of coverage with a specified retroactive coverage date. Thereafter and subject to the terms, conditions and exclusions of the Fairway Physicians Insurance Company policy, you will be entitled to claims defense and claims payment services described in your policy with FAIRWAY for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences subsequent to the retroactive date indicated in your certificate of insurance with FAIRWAY.

Retroactive coverage is only available from FAIRWAY to those applicants who have maintained continuous and uninterrupted "Claims-Made" medical professional liability coverage up to the commencement date of their coverage with FAIRWAY.

Whether or not you believe you were at fault:

1. **Are you aware of any incidents resulting in injury or death to a patient where your professional services were utilized?** q YES q NO

2. **Are you, your employers or associates aware of any threats or complaints that could lead to legal action against you or your medical practice?** q YES q NO

   If **Yes**, please indicate the number of threats or complaints and describe below (use separate paper if necessary):

   _____

   _____

3. **Have you ever been the subject of a deposition or subpoena as a result of medical services provided by you on behalf of a patient?** q YES q NO

OBLIGATION OF DISCLOSURE

State law requires you to disclose to Fairway Physicians Insurance Company ("FAIRWAY") any information known to you that would influence FAIRWAY's decision to approve your application for coverage, including the information you provided in this claims section. You also have an obligation to inform FAIRWAY of any information that becomes known to you between the date of your signature below and the effective date of coverage with FAIRWAY that could alter your previous response to the claims information requested herein. You are advised to notify FAIRWAY of any additional information not previously disclosed in your application for coverage.

q **YES**, I request retroactive coverage from FAIRWAY for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences and subsequent to my retroactive coverage date with FAIRWAY.

I represent and warrant that I will maintain my current professional liability coverage up to the commencement date of my membership with Fairway Physicians Insurance Company. I make this representation with the understanding that should any future investigation reveal that I did not maintain continuous claims-made professional liability coverage, FAIRWAY may deny all claims defense and claims payment services for any claim arising out of professional services that I rendered to patients during the retroactive coverage period.

I also make this representation with the understanding that my failure to meet my obligation of disclosure may result in the termination of my policy with FAIRWAY and the loss of all claims defense and claims payment services.

Requested Retroactive Date: _____ / _____ / _____
MM DD YYYY

q **NO**, I decline retroactive coverage from FAIRWAY.

This application for Retroactive Coverage is deemed part of your Application for Membership in FAIRWAY and is incorporated by this reference into the FAIRWAY policy.

I declare under penalty of perjury that the foregoing is true and correct. Executed this _____ of
DAY

_____, 200____ in _____, _____, by _____.
MONTH YR CITY STATE SIGNATURE

ALLIED HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

X. APPLICANT RETROACTIVE COVERAGE (CONTINUED)

DISCLOSURES

REPRESENTATIONS AND WARRANTIES: I hereby warrant the truth of all statements and answers contained in this application. I have not withheld any facts about my professional practice which are reasonably calculated to or may influence the judgment of Fairway Physicians Insurance Company in considering this application. I understand that if I have withheld any material facts concerning the risk exposure of my professional practice and FAIRWAY is made aware of my lack of disclosure, I will have no coverage for any claims that may arise due to my lack of disclosure and my coverage with FAIRWAY may be declined. I agree to notify FAIRWAY in a timely manner of any change to my practice or to the information regarding an open claim or incident as it becomes available to me. I acknowledge that coverage through FAIRWAY is governed by the terms of my FAIRWAY policy. I agree that upon FAIRWAY's acceptance of my application, my execution of the insurance agreement and the initiation of payments of my insurance premium, I will be deemed to have professional liability coverage by Fairway Physicians Insurance Company. I understand that my execution of this application does not bind FAIRWAY to admit me as a member in FAIRWAY, nor does it bind me to become a member of FAIRWAY, if accepted. In addition, I understand and agree that I have no right to receive any information regarding the basis or reasons by FAIRWAY concerning my application for coverage. I further understand that my membership and my professional liability coverage does not become effective until my application has been accepted by FAIRWAY and payments for coverage have been received.

ARBITRATION: I agree that any dispute or controversy arising out of or in connection with this application shall be submitted to, determined and resolved by, binding arbitration before three (3) arbitrators. The arbitration shall be conducted pursuant to my underwriting policy.

REFERENCES: I authorize and direct any individual, government agency, medical society, physician, hospital, insurance agent or company representative to furnish information concerning me or my medical practice which FAIRWAY may require. This authority extends to the release of information regarding professional liability coverage and claims. I also agree that any person or organization, together with the officers, directors and agents, will not be liable in any way for furnishing such information even though the information may be incomplete or incorrect.

Should I employ the services of an insurance broker/consultant through FAIRWAY to assist me in securing professional liability coverage, I hereby authorize FAIRWAY to release any and all necessary information to such individuals or agency/organizations.

NAME OF APPLICANT (PLEASE PRINT)	SIGNATURE OF APPLICANT	/ / DATE

XI. COVERAGE INFORMATION

1. Requested Effective Date: ____/____/____ **Requested Retroactive Date:** ____/____/____

IMPORTANT: The Declarations Page or Certificate of your current policy must be attached if a retroactive date is requested. The company may not provide requested dates.

2. Policy Limits:

Coverage is solely as stated in your FAIRWAY policy, and provided on a "*Claims-Made*" basis for **those claims first reported (i.e. "Tail Coverage") against the insured during the policy period** unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I warrant to FAIRWAY my understanding and acceptance of the notice stated above and that the information contained herein is true and shall be inclusive of the basis of the policy of insurance and deemed incorporated therein, should the insurer evidence its acceptance of this application by issuance of a policy. **I authorize the release of all claims information from any prior insurer to Fairway Physicians Insurance Company.**

NAME OF APPLICANT (PLEASE PRINT)	
SIGNATURE OF APPLICANT	/ / DATE

Signing this application does not bind the applicant or the insurer or the underwriting manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.