



Atlantic Specialty Lines, Inc.

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION

Agency Name: _____

Address: _____

Phone: _____

Please type or legibly print your responses in full. Please supplement this application with responses to questions requiring more room than contained in this form and submit copies of the documents requested on the last page of this application.

1. Name (First, Middle, Last): _____ M.D. D.O.

2. Social Security Number: _____

3. Date of Birth: _____ Male Female

4. E-mail Address: _____

5. Mailing address: _____

City, state, zip: _____

County: _____ Office telephone: _____ Office Fax: _____

Business manager/Contact person: _____ Telephone: _____

6. Principal office address (If different than mailing address): _____

City, state, zip: _____

County: _____ Office telephone: _____ Office Fax: _____

7. Other office location(s) (Please attach a separate sheet as required for additional office locations.):

City, state, zip: _____

County: _____ Residence telephone: _____ Residence Fax: _____

8. Residence address (If different than mailing address): _____

City, state, zip: _____

County: _____ Telephone: _____ Fax: _____

9. Requested limits of insurance:

- \$100,000 per incident/\$300,000 policy aggregate
- \$200,000 per incident/\$600,000 policy aggregate
- \$250,000 per incident/\$750,000 policy aggregate
- \$500,000 per incident/\$1,500,000 policy aggregate
- \$1,000,000 per incident/\$3,000,000 policy aggregate
- Other: \$ _____ per incident
\$ _____ policy aggregate

10. Requested effective date (12:01 a.m.): _____ Requested retroactive date (12:01 a.m.): _____

(Coverage is limited to claims, that are first made while the insurance is in force and that arise out of professional incidents that first occur on or after the retroactive date.)

11. Medical Specialty: _____

Board Certified? Yes No Certification Date: _____

Board Eligible? Yes No

If not Board Certified or Board Eligible, please explain: _____

12. Subspecialty: _____
 Board Certified? Yes No Certification Date: _____
 Board Eligible? Yes No
 If not Board Certified or Board Eligible, please explain: _____

13. List all states where you are licensed (attach a sheet of paper if additional space is needed):

State	License Number	Average number of hours per week per state
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14. Narcotics Drug Enforcement Agency Number: _____

15. List all hospitals and surgicenters where you have privileges and the percentage of your total hospital admissions (or surgeries) allocated to each (attach a sheet of paper if additional space is needed):

Name	City	State	Type of Privileges	% of Admissions
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
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16. List all medical societies, medical associations, or other related professional societies, to which you belong:

17. Name(s) of medical school(s):

Medical School	City	State/Country	Graduation Date
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18. If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates? Yes No

If "Yes," date certified: _____

If "No," please explain: _____

19. List all internship/residency training undertaken and dates, whether completed or not:

Location	Specialty	Mo./Yr. Completed
Served internship at: -----	-----	-----
Served residency at: -----	-----	-----
Served fellowship at: -----	-----	-----

20. Please describe, and provide dates for any major changes in your practice in the last ten years, such as changes of specialty, or significant procedures initiated or no longer performed: _____

21. List all practice locations within the ten years prior to this application, the current or most recent first:

Name	City/State	Dates at Location	Type of Practice
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22. Please indicate below your best estimate of the **number** of the following procedures you expect to perform, or in which you will participate in, within the next year, beginning with the date of your requested coverage:

<input type="checkbox"/> Abortion – first trimester <input type="checkbox"/> Abortion – after first trimester <input type="checkbox"/> Acupuncture <input type="checkbox"/> “Alternative medicine” or “complementary medicine” procedures (as viewed by most physicians) Please describe: _____ _____ _____ <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Anesthesia <input type="checkbox"/> General <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Other – Please describe: _____ _____ <input type="checkbox"/> Angiography/Angioplasty <input type="checkbox"/> Arteriography <input type="checkbox"/> Assisting in major surgery – own patients <input type="checkbox"/> Assisting in major surgery – other than own patients <input type="checkbox"/> Barium enema or barium swallow <input type="checkbox"/> Botox injections <input type="checkbox"/> Breast implants and/or reduction <input type="checkbox"/> Catheterization: <input type="checkbox"/> Cardiac <input type="checkbox"/> Arterial <input type="checkbox"/> Urinary <input type="checkbox"/> Other – Please describe: _____ _____ <input type="checkbox"/> Chelation therapy <input type="checkbox"/> Chemabrasion <input type="checkbox"/> Chemical peel <input type="checkbox"/> Cholangiogram <input type="checkbox"/> Circumcision <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cosmetic implantation or injection of silicone or other materials – Please describe: _____ _____ <input type="checkbox"/> Cryosurgery – Please describe: _____ _____ <input type="checkbox"/> Cystoscopy <input type="checkbox"/> D & Cs <input type="checkbox"/> Deliveries: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean <input type="checkbox"/> Vaginal after Cesarean <input type="checkbox"/> Discograms <input type="checkbox"/> Electromyography <input type="checkbox"/> Endoscopy (other than proctoscopy or sigmoidoscopy) – Please describe: _____ _____	<input type="checkbox"/> Eyeliner pigmentation <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture reductions – closed <input type="checkbox"/> Fracture reductions – open <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Hair transplants, or other hair growing or replacement techniques <input type="checkbox"/> Hemorrhoidectomy: <input type="checkbox"/> Internal <input type="checkbox"/> External <input type="checkbox"/> Intravenous Pyelogram (IVP) <input type="checkbox"/> Laparoscopy: Please describe: _____ _____ <input type="checkbox"/> Laser skin resurfacing <input type="checkbox"/> Laser hair removal <input type="checkbox"/> Laser surgery – Other – Please describe: _____ _____ <input type="checkbox"/> Liposuction <input type="checkbox"/> Lumbar puncture <input type="checkbox"/> Myelography <input type="checkbox"/> Needle aspiration/biopsy – Breast <input type="checkbox"/> Needle aspiration/biopsy – Other Please describe _____ _____ <input type="checkbox"/> Ophthalmology – Invasive procedures involving the eye <input type="checkbox"/> Pacemaker insertion <input type="checkbox"/> Penile implants <input type="checkbox"/> Pre-natal care <input type="checkbox"/> Radial keratotomy (Lasik Surgery) <input type="checkbox"/> Radiation oncology <input type="checkbox"/> Sclerotherapy <input type="checkbox"/> Shock therapy (ECT) <input type="checkbox"/> Spinal surgery <input type="checkbox"/> Tattoo removal <input type="checkbox"/> Thoracentesis <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Total joint replacement <input type="checkbox"/> Tubal ligations <input type="checkbox"/> Vasectomy <input type="checkbox"/> Venography <input type="checkbox"/> Weight control by means other than diet or exercise Please describe: _____ _____ <input type="checkbox"/> I DO NOT PERFORM ANY OF THESE PROCEDURES
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23. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of surgery:

<input type="text"/> Abdominal	<input type="text"/> Neurosurgical
<input type="text"/> Bariatric	<input type="text"/> Obstetrical
<input type="text"/> Cardiac	<input type="text"/> Ophthalmological
<input type="text"/> Cardiovascular disease	<input type="text"/> Orthopedic – including spinal surgery
<input type="text"/> Colon/rectal	<input type="text"/> Orthopedic – without spinal surgery
<input type="text"/> Emergency Medicine	<input type="text"/> Plastic – cosmetic
<input type="text"/> Gastroenterology	<input type="text"/> Plastic – reconstructive
<input type="text"/> General	<input type="text"/> Thoracic
<input type="text"/> Gynecologic	<input type="text"/> Traumatic
<input type="text"/> Hand	<input type="text"/> Urologic
<input type="text"/> Head and Neck	<input type="text"/> Vascular

24. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society? Yes No
25. Has any licensing authority ever refused you a license to practice medicine? Yes No
26. Has any licensing authority ever restricted, suspended or revoked your license to practice medicine? Yes No
27. Have you ever voluntarily surrendered a license to practice medicine? Yes No
28. Has any licensing authority ever placed you on probation or restricted your practice? Yes No
29. To your knowledge, is your license to practice currently under investigation? Yes No
30. Has any hospital or health care institution ever denied, restricted, reduced, or suspended your privileges or invoked probation? Yes No
31. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? Yes No
32. Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or a mental disorder or mental illness? Yes No
33. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine? Yes No
34. Have you ever been convicted of or are you currently under investigation for a crime other than a routine civil traffic offense? Yes No
35. Have you ever been refused board certification? Yes No
36. Have you ever had medical professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or has renewal been refused or not offered? Yes No
37. To your knowledge has any medical professional liability insurer ever considered such an action or is any such action being considered? Yes No
38. Have you ever "withdrawn" an application in anticipation of a declination or premium surcharge? Yes No
39. Do you intend to carry or do you currently carry any other medical professional liability insurance from any other insurer while this insurance is in effect?
If "Yes," please attach proof of coverage from the other insurer and explain. Yes No
40. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office? Yes No
41. Are you a medical director of any nursing home, health care facility or business enterprise providing medical services? Yes No
42. Are you an employee of, or do you perform contract work for any government agency? Yes No
43. Are you a sports team physician for any college, university or professional team? Yes No

44. Do you participate in any pharmaceutical testing programs? Yes No
 If "Yes," is it (are they) FDA-approved? Yes No
45. Do you treat or review treatment for jail or prison inmates? Yes No
 If "Yes," provide details on a separate sheet as to where and how often inmates are treated.
46. If coverage for this exposure is to be provided by a carrier other than a member of the Colony Group, please provide evidence of that other coverage.
47. Do you engage in any "moonlighting" activity apart from your practice? Yes No
48. Do you work in an emergency room? Yes No
 If "Yes," how many hours on average per week _____
 If "Yes," for what institution? _____
49. If coverage is to be provided by a carrier other than the Colony Group, please provide evidence of that other coverage.
50. Do you use a collection agency? Yes No
 If "Yes," does the collection agency have authority to file a collection suit at its discretion? Yes No
51. Do you work with a blood/tissue/organ bank? Yes No
 If "Yes," please provide details: _____
52. If you are not a radiologist:
 a. Do you take and/or interpret your own X-rays or perform other imaging procedures? Yes No
 b. If "Yes," estimated number per year: _____
 c. Does a radiologist over-read your X-rays? Yes No
53. Do you perform surgery in your office? Yes No
 (Surgery other than incision of boils and superficial abscesses or suturing of skin or superficial fascia.)
 If "Yes," please list the specific procedures: _____
54. Is general anesthesia administered for these (or any) office procedures? Yes No
 If "Yes," by whom: _____ and with what training? _____
55. What specific emergency equipment do you have available in your office? _____
57. How far is this office location from the nearest hospital with emergency services? _____
58. Do you have privileges at the hospital identified in 58? Yes No
59. Do you perform invasive pain management procedures? Yes No
 If "Yes," please list the procedures you perform and indicate if each is done in a hospital or office: _____
60. Do you practice medicine in any internet or tele-medicine program? Yes No
 If "Yes," please provide details: _____
61. Does your practice have a web site? Yes No
 If "Yes," please provide the web-site address: _____
62. Average number of patients per week: _____

63. Average number of hours practiced per week: (including on call, charting, teaching, phone consultations, etc.)

64. Estimate the annual gross revenue of your practice:

- < \$100,001
- \$100,001 to \$250,000
- \$250,001 to \$500,000
- \$500,001 to \$750,000
- \$750,001 to \$1,000,000
- >\$1,000,000

65. Do you practice as an:

- a. Individual (solo practice)? Yes No
Name of solo professional corporation or service corporation: _____
Federal ID Number: _____
- b. Employee? Yes No
Name of employer: _____
- c. Independent contractor? Yes No
Name of hiring party: _____
- d. Partner/shareholder? Yes No
Name of corporation/partnership: _____
- e. Federal ID of this professional corporation or service corporation: _____ Yes No

66. Is coverage requested for this entity? Yes No

67. Please indicate the number of each of the following categories of health care providers you employ.

- | | |
|--------------------------------------|--------------------------------------|
| _____ Chiropractor | _____ Perfusionist |
| _____ Laboratory Services Technician | _____ Physician Assisant |
| _____ Medical Technician | _____ Podiatrist – Including Surgery |
| _____ Nurse – LPN | _____ Podiatrist – No Surgery |
| _____ Nurse – RN | _____ Psychologist |
| _____ Nurse Anesthetist | _____ Respiratory Therapist |
| _____ Nurse Midwife | _____ Surgeon Assistant |
| _____ Nurse Practitioner | _____ Surgical Assistant |
| _____ Occupational Therapist | _____ Ultrasound Technician |
| _____ Optometrist | _____ X-Ray Technician |
| _____ Other – please describe: _____ | |

68. Do you supervise any health care providers other than those employed at your practice? Yes No

If yes, please list facility, specialty and number supervised: _____

69. Do you supervise any residents or interns? Yes No

If yes, please describe: _____

70. Beginning with your most recent or current insurer, please list **ALL** current and prior medical professional liability insurers. Please explain any gaps in the continuity of your professional liability coverage.

Name of Insurer	Coverage Type (Occurrence or Claims-made)	Policy Number	Policy Period

71. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer? Yes No

Please provide a copy of the declarations page of your current coverage and any reporting period extension ("tail").

72. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged? Yes No

If "Yes," has such incident(s) been reported to a prior professional liability insurer and has that insurer acknowledged coverage for the incident(s)? Yes No

73. Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application. The name, age, and sex of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amount or current status must be included.

74. Do you have knowledge of any claims, potential claims, suits, or potential suits, whether valid or not, in which you, your employees, or persons for whom you are responsible, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim? Yes No

If "Yes," has this incident (these incidents) been reported to a prior insurer? Yes No

75. Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application.

*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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states

APPLICANT'S REPRESENTATIONS, WARRANTIES AND AUTHORIZATION

I understand that no coverage will be bound until after Colony has reviewed this completed application and formally bound the requested coverage. Acceptance of payment is not an expression of Colony's intent to provide coverage. If coverage is declined by Colony, any advance payment will be promptly returned.

I understand that no insurance will be provided for: 1.) any claim known to the insured which has, or has not, been reported to another insurance carrier prior to the effective date of this insurance; or 2.) any claim that may arise out of an incident which has, or has not, been reported to another insurance carrier prior to the effective date of this insurance.

I specifically represent and warrant to the insurer that the information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this application or that might be material to the acceptance of the risks described to the underwriter in this application. I further agree that any false or misleading statement in this application shall be grounds for the insurer to cancel and void coverage at its sole and absolute discretion.

I authorize the release of any underwriting and/or claim information (and release from any and all liability for the provision of information) from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals or health care institutions, to Colony, and its subsidiaries or agents.

I agree to cooperate with the Risk Management Department of Colony, and its subsidiaries or agents, and to support their efforts to enhance quality of patient care.

Signature	Title	Date
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Please attach:

- o Copy of current/most relevant medical license
- o Copy of board certification
- o Curriculum vitae
- o Copy of current declarations page
- o Supplemental claim form for each claim, regardless of outcome
- o Copy of letterhead or sample billing statement