Premium Indication Request for Physicians

Please read carefully before completing:

This is a premium indication request only. It is not an application for medical malpractice insurance coverage and does not, in any way, bind coverage. The information contained in this request will be used to acquire premium indications from one or more insurance carriers as appropriate and will otherwise be held in the strictest confidence.

SIGNATURE
After completing the premium indication request, the applicant's signature is required, along with the date. Please complete the request completely.

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. Each Claim Information Sheet must be completed, signed and dated.

RETROACTIVE ("NOSE") COVERAGE
If you wish to obtain nose coverage, a copy of your most recent declarations page from your current carrier indicating the original effective date of coverage and a current paid through date must be attached.

Tegner-Miller Insurance Brokers - CAMM
2001 Wilshire Boulevard Suite 101
Santa Monica, CA 90403
Phone: 800.775.8642
Fax: 310.453.7971
E-mail: insure@tmib.com
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. Taxpayer I.D. / Social Security Number ____________________________ Date of Birth __/__/____
   f. Mailing/Billing Address ____________________________________________
      City __________________ State _______________ Zip ______________

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

3. EFFECTIVE DATE
   Desired Effective Date ________________________________________________

4. LIMITS OF INSURANCE DESIRED
   Please consult your agent or broker for limits of insurance available under this policy.
   Limits Requested: Per Claim $ ___________________ Aggregate Per Policy Period $ ________________

5. RETROACTIVE (“NOSE”) COVERAGE
   Retroactive (“Nose”) coverage provides protection for claims first made against you after the effective date of
   coverage with the new 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
   new company for claims arising out of these acts or omissions.
   a. I would like to include retroactive (“Nose”) coverage in this premium indication request:  □ Yes  □ No

IF YES, YOU MUST ATTACH A COPY OF YOUR MOST RECENT DECLARATIONS PAGE FROM YOUR PRESENT CARRIER
INDICATING THE ORIGINAL EFFECTIVE DATE OF COVERAGE AND THE CURRENT PAID THROUGH DATE.
b. Retroactive date requested

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

6. PREVIOUS CARRIERS

a. List the name(s), policy number(s), and policy period(s) for all previous claims made insurance carriers:

<table>
<thead>
<tr>
<th>INSURANCE CARRIER(S)</th>
<th>POLICY NUMBER(S)</th>
<th>POLICY PERIOD(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>From</td>
</tr>
</tbody>
</table>

i. ____________________________________ _____________________ __________________________
   Month/Day/Year        Month/Day/Year

ii. ____________________________________ _____________________ __________________________
    Month/Day/Year        Month/Day/Year

iii. ____________________________________ _____________________ __________________________
     Month/Day/Year        Month/Day/Year

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.

<table>
<thead>
<tr>
<th>MEDICAL SPECIALTIES</th>
<th>INSURANCE CARRIER(S)</th>
<th>POLICY PERIOD(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>From</td>
</tr>
</tbody>
</table>

i. ____________________________________ _____________________ __________________________
   Month/Day/Year        Month/Day/Year

ii. ____________________________________ _____________________ __________________________
    Month/Day/Year        Month/Day/Year

iii. ____________________________________ _____________________ __________________________
     Month/Day/Year        Month/Day/Year
**SECTION III — MEDICAL SPECIALTIES INFORMATION**

* a. Is there documented communication between the Hospitalist and the attending/primary care physician?

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

* a. Is there documented communication between the Hospitalist and the attending/primary care physician?

IF NO, PROVIDE EXPLANATION IN THE REMARKS SECTION, PAGE 13.

b. Does the Hospitalist cover ER or do on-call for ER?

IF YES, PROVIDE EXPLANATION IN THE REMARKS SECTION, PAGE 13.

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 13.**

<table>
<thead>
<tr>
<th>a. Hospital Surgery as Primary Surgeon</th>
<th>i. Laser Refractive Surgery</th>
<th>m. Blepharopigmentation</th>
<th>n. X-Ray</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>b. Assisting in Surgery Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Office Surgery □ 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Surgery in Surgicenter □ 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Obstetrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Therapeutic Abortions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number performed monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Amniocentesis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Cosmetic/Plastic Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Minor □ 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Major</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Chemical Peels □ 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv. Hair Transplants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>v. Radiation Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vi. Scar Revisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vii. Sclerotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>viii. Silicone Injections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ix. Suction Liposuction □ 3 &amp; 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Fracture Reductions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Open</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Closed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Cardiac Catheterization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Right Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Left Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Anesthesia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. General</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Nerve Block</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Spinal/Caudal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv. Local</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. X-Ray</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Diagnostic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Therapeutic Radiation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Coronary Angiography</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Cerebral Angiography</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. Renal Dialysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. Electroconvulsive Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s. Endoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t. Sigmoidoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>u. Spinal Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>v. Weight Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Surgery □ 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Drugs - List Below</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>w. Laser Procedures □ 3 &amp; 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>x. Other □ 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3 PLEASE EXPLAIN (USE REMARKS SECTION, PAGE 13, FOR MORE DETAIL).

4 ATTACH PROOF OF TRAINING.

8. Do you currently perform radial keratotomy? □ Yes □ No

IF YOU NO LONGER PERFORM RADIAL KERATOTOMY, WHEN DID YOU LAST PERFORM THIS PROCEDURE? _____ / _____ / _____

9. 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 13.

10. 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

NOTE: COVERAGE IS EXCLUDED UNDER THE POLICY UNLESS SPECIFICALLY ENDORSED.

11. 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 ________________________________________________

  □ Yes □ No

g. Do you have professional liability insurance for your Emergency Room Practice?
  □ Yes □ No

  **IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 13.**

12. Are you a County Medical Association, Society or Osteopathic Society Member?
  □ Yes □ No

  **IF YES, PLEASE NAME THE ORGANIZATION(s) ____________________________**

______________________________

**GENERAL ANESTHESIA INFORMATION (ORAL/MAXILLOFACIAL SURGEONS ONLY)**

13. Do you use or have:

a. Oral/Maxillofacial Anesthesia Permit No. __________________________ State__________ Expiration Date ___/___/___

  □ Yes □ No

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 CO\(_2\) 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 is devoted to showing where you practice and the relationships you have in your practice with others (if any). We have loosely termed the others with whom you practice “organizations”, but it could refer to individuals as well (see further examples in the “Explanation of Question a.” 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.

On the next three pages (7, 8 and 9) of this Section, Questions 14., 15. and 16. ask about three (3) practice locations separately. If you practice at more than three (3) locations, please provide the same information in the Remarks Section Page 13.

If you practice at a location for which insurance coverage will be provided elsewhere, please provide information for that practice, but clearly indicate that coverage is not desired at that location.

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

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

**Explanation of Question f.):** 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.
14. PRIMARY PRACTICE LOCATION  Coverage 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; OR □ are you employed or retained by another physician at this location?
      His/Her Name____________________________ Carrier ____________________________
      His/Her Name____________________________ Carrier ____________________________
   h. State the names of the following types of individuals who provide services in your office and indicate whether salaried employees or independent contractors. LIST ADDITIONAL EMPLOYEES IN REMARKS SECTION, PAGE 13.
      • Acupuncturist □ Salaried Employee □ Independent Contractor
      • Certified Nurse Midwife □ Salaried Employee □ Independent Contractor
      • Chiropractor □ Salaried Employee □ Independent Contractor
      • Dentist □ Salaried Employee □ Independent Contractor
      • Dietitian □ Salaried Employee □ Independent Contractor
      • Licensed Midwife □ Salaried Employee □ Independent Contractor
      • Nurse Anesthetist □ Salaried Employee □ Independent Contractor
      • Optometrist □ Salaried Employee □ Independent Contractor
      • Optician □ Salaried Employee □ Independent Contractor
      • Perfusionist □ Salaried Employee □ Independent Contractor
      • Pharmacist □ Salaried Employee □ Independent Contractor
      • Physician Assistant □ Salaried Employee □ Independent Contractor
      • Registered Nurse Practitioner □ Salaried Employee □ Independent Contractor

   i. Indicate the number of the following types of other individuals who provide services at this location:
      _______ 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

   1 YOU MUST ATTACH A COPY OF THE PHYSICIAN ASSISTANT’S LICENSE AND THE SUPERVISING PHYSICIAN’S LICENSE.
   2 PLEASE ATTACH A COPY OF THEIR LICENSE.

   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.
15. SECONDARY PRACTICE LOCATION  Coverage 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; OR
   □ are you employed or retained by another physician at this location?
   His/Her Name_________________________________ Carrier __________________

h. State the names of the following types of individuals who provide services in your office and indicate
   whether salaried employees or independent contractors. LIST ADDITIONAL EMPLOYEES IN REMARKS SECTION, PAGE 13.

   • Acupuncturist   • Dietitian   • Optometrist   • Podiatrist
   • Certified Nurse Midwife   • Licensed Midwife   • Perfusionist   • Psychological Assistant 2
   • Chiropractor   • Nurse Anesthetist   • Pharmacist   • Psychologist 2
   • Dentist   • Optician   • Physician Assistant 1   • Registered Nurse Practitioner2

   Name   Title
               
               
               
               
               
   Salaried Employee □   □
   Independent Contractor □   □

1 YOU MUST ATTACH A COPY OF THE PHYSICIAN ASSISTANT’S LICENSE AND THE SUPERVISING PHYSICIAN’S LICENSE.
2 PLEASE ATTACH A COPY OF THEIR LICENSE.

i. Indicate the number of the following types of other individuals who provide services at this location:

   ______ 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.
16. **ADDITIONAL PRACTICE LOCATION** Coverage 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; OR

   ☐ are you employed or retained by another physician at this location?

   His/Her Name_________________________________ Carrier __________________

   His/Her Name_________________________________ Carrier __________________

h. State the names of the following types of individuals who provide services in your office and indicate whether salaried employees or independent contractors. **LIST ADDITIONAL EMPLOYEES IN REMARKS SECTION, PAGE 13.**

<table>
<thead>
<tr>
<th>Type of Individual</th>
<th>Name</th>
<th>Title</th>
<th>Salaried Employee</th>
<th>Independent Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncturist</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chiropractor</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dietitian</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Licensed Midwife</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Optometrist</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Optician</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Perfusionist</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Physician Assistant ¹</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Podiatrist</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Psychological Assistant ²</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Psychologist ²</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Registered Nurse Practitioner ²</td>
<td></td>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

¹ YOU MUST ATTACH A COPY OF THE PHYSICIAN ASSISTANT’S LICENSE AND THE SUPERVISING PHYSICIAN’S LICENSE.

² PLEASE ATTACH A COPY OF THEIR LICENSE.

i. Indicate the number of the following types of other individuals who provide services at this location:

<table>
<thead>
<tr>
<th>Type of Individual</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologist</td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td></td>
</tr>
<tr>
<td>Hearing Aid Dispensers</td>
<td></td>
</tr>
<tr>
<td>Medical/Dental Assistant</td>
<td></td>
</tr>
<tr>
<td>Nurse (Registered or Vocational)</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Speech Pathologist</td>
<td></td>
</tr>
<tr>
<td>Technician (Lab, Pathologist)</td>
<td></td>
</tr>
<tr>
<td>Technician (X-Ray, Radium)</td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
</tr>
</tbody>
</table>

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.
SECTION V — OTHER PROFESSIONAL DUTIES

17. 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 13.

18. 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 ____________________________________

NOTE: COVERAGE IS EXCLUDED FOR ADMINISTRATIVE ACTIVITIES UNLESS YOU ARE A RADIOLOGIST OR PATHOLOGIST OR UNLESS SUCH ACTIVITIES CONSTITUTE PROFESSIONAL COMMITTEE ACTIVITIES.

19. Are you employed by a state, federal or local public entity?

☐ Yes  ☐ No

IF YES, PLEASE COMPLETE SECTION IV WITH REGARD TO THAT PRACTICE.

20. If the total hours of practice described in the previous pages (7, 8 and 9) equal less than 20 hours, how is the remainder of your professional time spent?___________________________________________________________

SECTION VI — MEDICAL EDUCATION AND PRACTICE INFORMATION

21. NAME (SCHOOL OR HOSPITAL)  DATES  SPECIALTY (IF APPLICABLE)

   a. Medical School ___________________________________________ to ____________
      Address ___________________________________________________________________

   b. Internship ___________________________________________ to ____________
      Address ___________________________________________________________________

   c. Residency I ___________________________________________ to ____________
      Address ___________________________________________________________________

   d. Residency II ___________________________________________ to ____________
      Address ___________________________________________________________________

   e. Fellowship ___________________________________________ to ____________
      Address ___________________________________________________________________
22. I have practiced at the following locations during the past ten (10) years (not including training).

   a. ____________________________________________________________ to ______________
      Name of Practice Month/Year Month/Year
      Type of Practice (i.e., Medical Group, HMO) Address City State Zip

   b. ____________________________________________________________ to ______________
      Name of Practice Month/Year Month/Year
      Type of Practice (i.e., Medical Group, HMO) Address City State Zip

   c. ____________________________________________________________ to ______________
      Name of Practice Month/Year Month/Year
      Type of Practice (i.e., Medical Group, HMO) Address City State Zip

   d. ____________________________________________________________ to ______________
      Name of Practice Month/Year Month/Year
      Type of Practice (i.e., Medical Group, HMO) Address City State Zip

   LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 13.

SECTION VII — UNDERWRITING INFORMATION

23. 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 13) AND INCLUDE COMPANY NAME AND POLICY NUMBER.

24. 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 13.

25. 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 14, FOR EACH CLAIM.

26. 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 13.

27. 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 13.

28. Have you ever had your hospital privileges reduced, restricted, preceptored or suspended? □ Yes □ No
   
   IF YES, DESCRIBE THE CIRCUMSTANCES IN REMARKS SECTION, PAGE 13.

29. 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 %

   LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 13.
30. Briefly describe the type(s) and extent of your hospital privileges: ________________________________________________
______________________________________________________________________________________________

31. 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 13.**

32. How did you become aware of us?

☐ Medical Association/Society ☐ Physician Colleague ☐ Mailing

☐ Advertisement ☐ Presentation by a Company Representative

☐ Other _____________________________________________________________________________________

33. My decision to apply was primarily based on:

☐ Reputation of Company ☐ Premium Considerations ☐ Coverage Quality

☐ Special Features ☐ Joining a Company Insured Group

☐ Other _____________________________________________________________________________________

34. 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. Please attach copies of the claimant’s office and hospital records, laboratory reports and any other information that would be appropriate. Attach additional sheets as required.

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)
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Date ________________________ Signed ________________________________

14
I HEREBY REPRESENT THAT THE STATEMENTS AND ANSWERS MADE WITHIN THIS PREMIUM INDICATION REQUEST ARE FULL, COMPLETE AND TRUE. ALSO, I UNDERSTAND THAT THIS IS NOT AN APPLICATION FOR INSURANCE OR A BINDER OF INSURANCE, BUT IS INSTEAD AN INSURANCE PREMIUM INDICATION REQUEST. A COMPLETED APPLICATION AS WELL AS UNDERWRITING REVIEW WILL BE NECESSARY PRIOR TO APPROVAL.

Name (Please type or print name)   Signature (Please sign your name)

Address   City   State   Zip

Date