

APPLICATION FOR MEDICAL PROFESSIONAL LEGAL EXPENSE REIMBURSEMENT

NOTICE: This Application is for Medical Professional Legal Expense Insurance. In consideration of a reduced premium, the coverage and obligations of the Company are significantly limited. The limitations include, but may not be limited to, the following:

- 1. This is a "CLAIMS MADE" and reported policy. This policy applies only to those claims first made against you and reported to the Company during the policy period or within sixty (60) days after the expiration of the policy period.
2. Coverage under this policy only reimburses you for certain legal defense costs described in the policy. The policy does not provide any indemnification for awards, verdicts, settlements, judgments or other loss.
3. The Company assumes no obligation to investigate, evaluate, settle or defend any claim against you. The only obligation of the Company is to reimburse you for covered legal expenses incurred by you in the defense of a covered claim.
4. You are required to arbitrate any disputes with the Company, and specifically waive your right to sue the Company and your right to seek punitive, exemplary or non-contractual damages.

Please read the policy carefully and discuss with your attorney or insurance professional.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

- 1. (a) (i) Full name of Applicant:
(ii) Professional Degree:
(b) Principal practice address: (Street) (County) (City) (State) (Zip)
(c) Secondary practice locations:
(d) (i) Phone: (ii) Fax:
(iii) E-Mail Address: (iv) Website Address:
(e) (i) DEA License No: (ii) Place of Birth:
(f) (i) Social Security No.: (ii) Federal Tax ID Number:

2. Are you a U.S. citizen? [] Yes [] No
If No, what is your status in the U.S. and current citizenship?

- 3. (a) Type of practice: [] solo practitioner (unincorporated) [] solo practitioner (incorporated)*
[] professional corporation* [] professional association*
[] limited liability company* [] partnership*
[] employee of [] independent contractor of
[] other
* Specify name of entity:

4. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

Table with 5 columns: Name, City, State, Percentage of Work, Type of Privileges

5. Are you currently a hospital chief of staff or head of any hospital department? [] Yes [] No
 If Yes, describe. _____

II. EDUCATION AND TRAINING

1. (a) Provide your medical or surgical specialty: _____
 (b) Do you limit your practice to the specialty stated in item (a) above? [] Yes [] No
 (c) Do you have a subspecialty? [] Yes [] No
 If Yes, describe. _____

2. Are you American Board certified? [] Yes [] No
 If Yes, provide the following: Medical specialty in which you are certified: _____
 Date of certification: _____ Any recertification date(s): _____
 If No, do you plan on taking the Board examination? [] Yes [] No

3. Provide the following information:

	<u>Name of Institution</u>	<u>City</u>	<u>State</u>	<u>Date Completed</u>
Medical School	_____	_____	_____	_____
PGY-1/Internship	_____	_____	_____	_____
Residency – Specialty: _____	_____	_____	_____	_____
Residency – Specialty: _____	_____	_____	_____	_____
Fellowship – Specialty: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

4. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? [] Yes [] No
 If Yes, provide the following: year of certification: _____ describe your medical degree: _____

III. SCOPE OF PRACTICE

1. (a) Average weekly patient load: _____ (b) Number of patients annually: _____
 2. Average number of hours you practice each week: _____
 3. Do you supervise anyone other than your own employees? [] Yes [] No
 If Yes, indicate by profession the number of individuals you supervise:
 ___ Physicians other than yourself ___ Podiatrists ___ Chiropractors ___ Optometrists
 ___ Physician’s Assistants ___ Nurses ___ Nurse Practitioners ___ Nurse Anesthetists
 ___ Surgeon’s Assistants ___ Nurse Midwives ___ Psychologists
 ___ Radiology Technicians ___ Laboratory Technicians ___ Other (describe) _____

Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. _____

IV. INSURANCE INFORMATION

Important Note to Applicants Having a Prior Claims-Made Insurance Policy

Unless you purchase tail coverage on your expiring coverage, you will not be covered under that policy for claims that first arise after the termination date of your policy. The policy for which you are now applying provides coverage only for legal expenses and not for any damages that may be awarded against you. If you are leaving a claims-made insurance policy that provides indemnity coverage for damages, for your protection, you should review the reporting requirements of your expiring policy and report any incidents that could reasonably result in a claim before it terminates.

1. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

2. Are you currently covered for Medical Professional Liability coverage, either as an individual or of a member of a practice, group, or association or other provider? [] Yes [] No
If yes, please describe and attach a copy of your current Declarations page or Certificate of Insurance. _____
3. Do you currently participate in any state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? [] Yes [] No

V. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance?..... [] Yes [] No
If Yes, how many? _____ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? [] Yes [] No
If Yes, how many? _____ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney that may result in a malpractice claim or suit? [] Yes [] No
If Yes, how many? _____ Completed a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges?..... [] Yes [] No
5. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?..... [] Yes [] No
6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? [] Yes [] No
7. Are you aware of any claims or potential claims that have been reported to your current or prior insurance carriers?..... [] Yes [] No
If Yes, please explain _____

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

Shand Morahan & Company, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which Shand Morahan & Company, Inc. receives notice is on file with Shand Morahan & Company, Inc. and is considered physically attached to and part of the of the policy if issued. Shand Morahan & Company, Inc. and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Shand Morahan & Company, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

Any person who knowingly and with intent to injure, deceive or defraud any insurer, files any statement of claim or an application of insurance containing any false or incomplete information or conceals information for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

By signing below, I hereby acknowledge, certify and warrant on behalf of myself, and all applicants:

1. I hereby certify and warrant that the above statements, representations and responses are true, complete and correct and I understand and agree that the Company will rely on such statements, representations and responses in making a decision as to whether to issue a policy to me. If the answer contained in the application or this certification materially changes during any policy period, I agree to immediately notify you. If transmitted to the Company by facsimile, I agree that the facsimile copy of this Application received by the Company shall be, and have the same effect for all purposes, as the original.
2. I hereby authorize any person or organization, including attorneys who now, or in the past have represented me, to release to the Company any and all information, whether privileged or not, relating to my employment, education, training, hospital privileges, my malpractice insurance (including but not limited to the underwriting and claims files of any current or former malpractice carrier insuring me), and any and all information which the Company, or Shand Morahan & Company, Inc, its underwriting manager may reasonably request to assist it in underwriting my application for insurance or in administering any claim made against me under my insurance policy with the Company.
3. The Legal Defense Policy applied for is a legal expense reimbursement policy ONLY, and the Company has no obligation to defend, investigate, evaluate or settle any claim under the policy.
4. Under the terms of the policy, I am giving up my right to litigate any dispute with the Company, as well as limiting damages that I may collect in the event of a dispute.
5. This policy probably will not meet the physician responsibility requirements of most states and that I therefore must independently verify the requirements of my state and comply with such provisions.

Must be signed by the Applicant within 60 days of the proposed effective date.

I have read and understand the above.

Name of Applicant

Title

Signature of Applicant

Date

