Kaigler & Company 7028 Church St. East Brentwood TN 37027

Physicians and Surgeons Application – Claims-Made Coverage

General Information

1. Social Security #:
2. Corporate I.D. # (if applicable):
3. Insured Name:
   First Middle Last Suffix Title
4. Male or Female: M F
5. Date of Birth:
6. Formal name of Partnership, Corporation, or Employer:

Addresses

7. Practice Addresses: Please list all office locations where you currently practice. List primary practice office first. Use the "Remarks Section", on page 10, to list additional locations at which you render professional services.
   a. Street:
      Bldg./Suite#:
      City, State, Zip:
      County:
      Number of years at this location: % of Practice:
   b. Street:
      Bldg./Suite #:
      City, State, Zip:
      County:
      Number of years at this location: % of Practice:
   c. Street:
      Bldg./Suite #:
      City, State, Zip:
      County:
      Number of years at this location: % of Practice:
8. Home Address:
   Street:
   Apt. #:
   City, State, Zip:
9. Telephone/Email address:
   Primary Practice Office:
   Fax:
   Home:
   Email Address:
   Web Site Address:
10. Billing Address if other than primary practice office:
    Company Name:
    Street:
    Bldg./Suite:
    City, State, Zip:

Education

11. Medical School:
    Name:
    City, State, Country:
    Degree:
    Dates:
12. Additional Education (if more than two residencies, one fellowship, or other training program, please provide details in the "Remarks Section" on page 10.
    a. Internship Hospital:
       City, State:
       Dates:
    b. Residency Hospital:
       City, State:
       Dates:
       Type:
    c. Residency Hospital:
       City, State:
       Dates:
       Type:
    d. Fellowship Hospital:
       City, State:
       Dates:
       Type:
    e. Other Training Location:
       City, State:
       Dates:
       Type:

Specialty

13. If you are a graduate of a non-US medical school, are you certified by the Educational Council for Foreign Medical School Graduates? Yes No
14. Primary Specialty:
    Name of Specialty:
    % of Practice:
    Are you board certified? Yes No If yes, date:
    Name of board:
    If not board certified, what is the expiration date of eligibility?
    If expired, why:

15. Secondary Specialty:
    Name of Specialty:
    % of Practice:
    Are you board certified? Yes No If yes, date:
    Name of board:
    If not board certified, what is the expiration date of eligibility?
    If expired, why:

Licenses, Affiliations

16. Specify States where you are or have been licensed:

    State: Year: License #: Permanent or Temporary *Status:
    State: Year: License #: Permanent or Temporary *Status:
    State: Year: License #: Permanent or Temporary *Status:
    State: Year: License #: Permanent or Temporary *Status:

    *If any of your licenses are or have been inactive, suspended, restricted, or revoked, please explain in the "Remarks Section" on page 10.

17. Affiliations/Associations/Society Membership
    a. Are you a member of any national (not specialty) medical societies? Yes No
    b. If yes, list:
    c. Are you a member of any national medical specialty societies? Yes No
    d. If yes, list:
    e. Are you a member of any state medical society? Yes No
    f. Are you a member of any county medical society? Yes No

Practice History

18. Are you entering practice for the first time since completing an internship, residency program, fellowship, or military service? Yes No
19. Indicate your number of practice hours per week (include office hours, administrative activities, direct patient care, surgery, consultation, etc.). Please indicate only the practice hours to be insured by the company.

20. Estimate the number of patients you see on an average day of clinical practice:
21. Indicate the number of weeks per year you practice (include office hours, administrative activities, direct patient care, surgery, consultation, etc.):
    a. If less than 26 weeks, are the weeks all consecutive? Yes No
    b. Maximum number of consecutive weeks out of practice:

Prior Practice Locations

22. Where have you practiced your profession for the past 10 years other than your current practice locations? Please explain any gaps in your practice. Use the "Remarks Section" on page 10 to list additional locations.

    Entity Name:
    Address:
    City, State:
    Dates:

    Entity Name:
    Address:
    City, State:
    Dates:

Entity Name:
Address:
City, State:
Dates:

Entity Name:
Address:
City, State:
Dates:

Entity Name:
Address:
City, State:
Dates:

Teaching/Medical Directorship Responsibilities

23. Do you have any teaching or medical director responsibilities? Yes No
    If yes, complete the following questions. Use "Remarks Section" on page 10 if needed.
    a. Name of Facility and Location:

    b. What is your title?
    c. Describe your responsibilities

    d. Does the entity provide you with coverage for:
        i. Your administrative responsibilities? Yes No
        ii. Your direct patient care? Yes No
    e. If teaching, what percentage of your weekly time is devoted to clinical teaching?

Staff Privileges

24. List all facilities, including non-hospital facilities, where you have staff privileges. List principal location first. Use "Remarks Section" on page 10 to list additional facilities.

    Facility:
    City, State:
    Department: % of Practice:

    Facility:
    City, State:
    Department: % of Practice:

    Facility:
    City, State:
    Department: % of Practice:

    Facility:
    City, State:
    Department: % of Practice:

Employed Personnel

25. If you or your entity employs or contracts for the services of any health care personnel in the following categories indicated by a *, a separate application form must be submitted for each.
    a. Physician's Assistants*
        i. Number employed:
        ii. Number Contracted:
        iii. Insurer, if any:
    b. Nurse Practitioners*
        i. Number Employed:
        ii. Number Contracted:
        iii. Insurer, if any:
    c. Certified Registered Nurse Anesthetists*
        i. Number Employed:
        ii. Number Contracted:
        iii. Insurer, if any:
    d. Certified Nurse Midwife*
        i. Number Employed:
        ii. Number Contracted:
        iii. Insurer, if any:
    e. List other paramedical personnel, including nurses, technicians, technologists, physical therapists, etc.:

        i. Number Employed:
        ii. Number Contracted:
        iii. Insurer, if any:

Changes in Practice

26. Have your practice specialties/procedures changed in the past 5 years? Yes No
    If yes, please explain how the specialty/procedures, etc. have changed and give the dates of changes:

Procedures

27. If you are not an anesthesiologist, do you perform:
    a. Intravenous Analgesia? Yes No
    b. If yes, what type?
    c. Anesthesia – General? Yes No
    d. Spinal? Yes No
    e. Intravenous? Yes No

28. Do you practice in any office surgical facility in which IV analgesia or general anesthetics are administered? Yes No
    a. If yes, list facilities:
    b. If yes to question #28, is the office certified by AAAASF or AAAHC? Yes No
    c. If yes to question #28b, please submit a copy of current certification. If no, please complete the supplemental surgery suite questionnaire.
29. Do you perform elective cosmetic surgery? Yes No
    If yes, do you perform the following?
    a. Blepharoplasty? Yes No
    b. Cosmetic Surgery of the breast? Yes No
    c. Chemical Peel? Yes No
    If yes, what kind?
    d. Dermabrasion/Chemabrasion? Yes No
    e. Suction-assisted Lipectomy? Yes No
    If yes, please provide proof of training, copy of consent form, and proof of hospital privileges for this procedure.
    f. Endoscopic-assisted forehead lifts? Yes No
    If yes, please provide proof of training (12 hours of AMA category ICME credit) and hands-on experience.
30. Do you practice neonatology (treatment of critically ill or premature neonates)? Yes No
    If yes, % of practice:
31. Do you practice obstetrics? (obstetrics includes prenatal care) Yes No
    a. Do you perform deliveries other than in a hospital? Yes No
    b. If yes, specify facility:
    c. Do you perform obstetrical home deliveries? Yes No
32. Do you perform abortions? Yes No
    a. If yes, First Trimester? Yes No
    b. Second Trimester? Yes No
    c. Third Trimester? Yes No
    d. List facilities where you perform abortions:
    e. Number of abortions per month:
    f. Do you receive referrals? Yes No
    g. If yes to question 32f, from whom?
33. If you are a pathologist, do you routinely perform frozen sections and gross surgical pathology examinations and then send material to an unrelated group of pathologists for microscopic examination and final sign off? Yes No
34. Do you perform radial keratotomy? Yes No
35. Do you perform sex reassignment surgery? Yes No
36. Do you perform weight-control surgery? Yes No
37. If you are a cardiologist, do you perform invasive procedures? Yes No
    If yes, specify the procedures:

38. If you are a dermatologist, do you make your own histopathologic diagnosis of pigmented lesions? Yes No

Miscellaneous

If you answer yes to any of questions 39 through 47c, please give full details in the "Remarks Section" on page 10. Include dates and copies of related documents.

39. Are you now being, or have you ever been, treated for alcoholism, narcotics addiction, or mental illness? Yes No
    If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from you treating physician or institution.
40. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? Yes No
    If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.
41. Have you ever had professional liability insurance declined, non-renewed, canceled, or restricted or had an involuntary deductible and/or surcharge assessed against you? Yes No
42. Have you ever been investigated by any state licensing board, narcotics board, DEA or other government or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended, or limited in any way? Yes No
    If yes, please provide copies of complaint and disposition documents.
43. Has any hospital ever restricted or revoked you privileges or invoked probation for any cause other then incomplete charts? Yes No
44. Have you ever been indicted and/or convicted of a crime other than minor traffic violations? Yes No
45. Have you ever been suspended, restricted, or put on probation by any government health program (e.g., Medicare or Medicaid)? Yes No
46. Have you been involved in a malpractice claim, suit, or incident in the past 10 years? Yes No
    If yes, how many?
    If yes to question #44, please provide complete details on the Claim Information Form on page 11. Complete a separate form for each claim.
47. Will you purchase an extended reporting endorsement (tail coverage) from your current carrier? Yes No
    a. Are you, as of this date, aware of any claims against you that have not been reported to your present or prior insurer(s)? Yes No
    b. Does your current carrier(s) consider a claim to be a _____ report of a medical incident or _____formal demand for money?
    c. Are you, as of this date, aware of any conduct, circumstances, or incidents that occurred during the period of coverage listed below that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)? Yes No

Initials Required

I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier.

_____ _____
Initials Date

Type of Practice

48. What is your practice structure and your relationship, if any, with others in your practice?
    Individual:
    Individual with DBA:
    Individual with a solo corporation:
    Other (describe):

49. Do you employ any physicians beside yourself in your practice? Yes No
    If yes, list details:

50. Do you independently contract with any entities or physicians not insured? Yes No
    If yes, list details:

    a. If you are an independent contractor, please complete the following statement:

    My association with _____
    Group/Physicians Name
    Is that of an Independent Contractor, and the relationship conforms to the guidelines of the Internal Revenue Service.

    _____ _____
    Signature Date Group Name

    _____
    Carrier

    A current declarations page or certificate of insurance for the above group must be attached.

51. Are you employed by any physicians or entities not insured? Yes No
    If yes, list details:

If yes to questions # 46, 47, or 48, indicate the names and addresses of all such groups, clinics, professional corporations, partnerships, commercial enterprises, government, or public entities. Show the date of affiliation, status of employment, hours worked (weekly), number of physicians at each of the entities, percentage of your practice this represents, and if malpractice insurance is provided for this work. If more than one facility, please explain in the "Remarks Section" on page 10.

Previous Insurance

52. To assure that there are no gaps in coverage, please list all previous medical professional liability insurance carried during the past 10 years, beginning with your current carrier. Use the "Remarks Section" on page 10 to list additional carriers.
    Attach a copy of the Declarations Page from your most recent policy

    Current Carrier:
    Policy Period:
    Limits of Liability:
    Claims-Made or Occurrence?

    First Prior Carrier:
    Policy Period:
    Limits of Liability:
    Claims-Made or Occurrence?

    Second Prior Carrier:
    Policy Period:
    Limits of Liability:
    Claims-Made or Occurrence?

    Third Prior Carrier:
    Policy Period:
    Limits of Liability:
    Claims-Made or Occurrence?

Effective Date

53. Desired effective date:
54. Current policy expires:

Limits of Liability

55. Indicate limits of liability desired, if available:
    _____ $5,000,000/$1,000,000
    _____ $500,000/$1,500,000
    _____ $1,000,000/$3,000,000
    _____ Other (limits set by your state, etc.) Indicate amount:

Remarks Section

If additional space is needed, please use your letterhead. For question number, please indicate question number and letter (if applicable) – 12 and 23d for example.

Question Number	Remarks

AGREEMENT: I understand that the persons or entities proposed for insurance are aware that the limits of liability contained in the policy applied for shall be reduced, and may be completely exhausted, by Defense Expenses and, in such an event, the Company shall not be responsible for the continued defense of any Claim or liable for Defense Expenses or for the amount of any judgment or settlement to the extent that any of the foregoing exceed the limits of liability of such policy.

AGREEMENT: I understand that Defense Expenses that are incurred shall be applied against the deductible amount.

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information and/or material misrepresentation will cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that the policy being applied for does not cover the liability of others that I may have assumed under contract or agreement. (Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed there under.)

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, and insurance agent to furnish any information concerning my medical practice or myself that the company may request.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

This insurance application, duly completed, together with any supplementary information must be signed, in ink, by the Applicant. One signed copy will be attached and form a part of any policy issued. Completion of the insurance application does not bind or obligate the Company to offer this insurance.

Signing this form, and tendering any payment, does not bind the Company or the applicant to complete the insurance. The insurance application must be signed to be considered for quotation. By signing below, you certify that all information you have provided is correct.

Signature required

_____ _____

Applicant Signature Date

Claim Information Form

Photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.

1. Name of patient:
2. Age:
3. Sex:
4. Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon, etc.):

5. Allegation:
6. Date of Incident:
7. Report Date:
8. Location:
9. Insurance Carrier:
10. Other Defendants:
11. Present Status:
    _____ Open Claim Loss of $: Settlement:
    _____ Closed Claim Date Closed: Judgment:
12. Condition and diagnosis at time of incident:

13. Dates and description of professional services rendered:

14. Condition of patient subsequent to professional services (and dates of follow-up visits) if known:

Signature required
I hereby declare the above information is complete and true to the best of my knowledge and belief.

_____ _____
Signature Date