

- General Star Indemnity Company
 General Star National Insurance Company

**PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE**

Please complete this application in ink and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

INSTRUCTIONS TO THE APPLICANT:

Your coverage cannot be renewed without this application completed in its entirety. If this application is not received by the Company, your coverage will expire at the end of your current policy period. Please answer all questions. If space is not sufficient to fully answer a question, attach a separate page.

I. GENERAL INFORMATION

Social Security #: _____ Current **GENERAL STAR** Policy #: _____
 Applicant's Name: _____ Date of Birth: _____
 Professional Designation: M.D. D.O. D.P.M. Other (describe) _____

1. Mailing Address: _____
 Street/P.O. Box City County State Zip Code

2. Primary Practice Location: _____ Number of years at this location: _____
 Street City County State Zip

3. Do you have more than one practice location? **If YES**, on a separate sheet please provide the following information: location address, hours of operation, procedures performed at each location, number of years at each location. Yes No

4. Office Telephone: _____ E-mail: _____
 Office facsimile: _____ Web Site: _____

5. Applicant is a(n): Individual Corporation LLC Partnership
 Employed Physician By Whom _____
 Other (describe): _____
 Practice is a: Solo Practice Group Practice
 Entity Name: _____ Applicant's percentage of ownership: _____%
 How many other physicians practice at this entity? _____
 Do you use any "doing business as" (d/b/a) name? Yes No
If YES, specify: _____

6. Residence Address: _____
 Street/P.O. Box City County State Zip Code
 Residence Telephone: _____

II. PRACTICE INFORMATION

MEDICAL SPECIALTY:	SUB-SPECIALTY:
AVERAGE WEEKLY PATIENT ENCOUNTERS :	AVERAGE WEEKLY PRACTICE HOURS:

Does your practice include the following? Check all that apply.

No Surgery No surgery with the exception of: suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.

<input type="checkbox"/> Minor Surgery	<p>Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures:</p> <ul style="list-style-type: none"> ▪ Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP), ▪ Pneumatic or mechanical esophageal dilation (not with bougie or olive), ▪ Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists who have completed a cardiovascular subspecialty training.), ▪ Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue, ▪ Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae <p><i>No procedures performed on a patient while under general anesthesia.</i></p>		
<input type="checkbox"/> Major Surgery	<p>Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography and radiation therapy. It also includes removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.</p>		
<input type="checkbox"/> Gynecology / Obstetrics	<p>If checked, please indicate which procedures:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Office Gynecology only <input type="checkbox"/> Pre-natal care through 1st trimester only <input type="checkbox"/> Pre-natal care through 2nd trimester only <input type="checkbox"/> Pre-natal care full term <input type="checkbox"/> Amniocentesis <input type="checkbox"/> High Risk Pregnancies <input type="checkbox"/> Toxemia Management <input type="checkbox"/> Dilatation and Curettage <input type="checkbox"/> Cryosurgery <input type="checkbox"/> Norplant Insertion </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Elective Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____ <input type="checkbox"/> Therapeutic Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____ </td> </tr> </table>	<input type="checkbox"/> Office Gynecology only <input type="checkbox"/> Pre-natal care through 1 st trimester only <input type="checkbox"/> Pre-natal care through 2 nd trimester only <input type="checkbox"/> Pre-natal care full term <input type="checkbox"/> Amniocentesis <input type="checkbox"/> High Risk Pregnancies <input type="checkbox"/> Toxemia Management <input type="checkbox"/> Dilatation and Curettage <input type="checkbox"/> Cryosurgery <input type="checkbox"/> Norplant Insertion	<input type="checkbox"/> Elective Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____ <input type="checkbox"/> Therapeutic Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____
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<input type="checkbox"/> Obstetrics	<p>Indicate annual number of:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Vaginal Deliveries: _____ Indicate the percentage of: Low forceps deliveries _____ % Mid forceps deliveries _____ % Breech Deliveries _____ % </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Cesarean Sections: _____ <input type="checkbox"/> VBAC Deliveries: _____ <input type="checkbox"/> Non-Hospital Deliveries _____ (Please describe circumstances on separate sheet) <input type="checkbox"/> Episiotomies: _____ </td> </tr> </table> <p>Do you personally attend each delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No Does a Midwife perform any actual deliveries/births? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, annual number performed by Midwife: _____</p>	<input type="checkbox"/> Vaginal Deliveries: _____ Indicate the percentage of: Low forceps deliveries _____ % Mid forceps deliveries _____ % Breech Deliveries _____ %	<input type="checkbox"/> Cesarean Sections: _____ <input type="checkbox"/> VBAC Deliveries: _____ <input type="checkbox"/> Non-Hospital Deliveries _____ (Please describe circumstances on separate sheet) <input type="checkbox"/> Episiotomies: _____
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<input type="checkbox"/> Radiology	<input type="checkbox"/> Diagnostic <input type="checkbox"/> Interventional Annual number of readings performed: _____ Type of readings performed: _____		
III. PROCEDURES/PRACTICE SPECIFICS			
Does your practice include the following (Check all that apply)?			
<input type="checkbox"/> Abortions	Number performed per month: _____ Where performed: <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic/Other: Please list location(s) on separate page. Maximum Gestation Age? _____		
<input type="checkbox"/> Elective Plastic Surgery	Type of Procedures: _____ Number performed per month: _____		
<input type="checkbox"/> Emergency Room Exposures	Do you work in an Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, is this solely to satisfy requirements for hospital privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No Indicate the average number of hours you work in the Emergency Room each month: _____		

<input type="checkbox"/> Nursing Home(s) & Long-Term Care Facilities	Are you an employee of - or under any contract to see Nursing Home patients? Provide details on a separate page.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you provide medical services to patients of nursing homes, long-term care facilities or other similar entities with over-night bed & board facilities? If Yes, provide details on a separate page.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	What percentage of your practice is devoted to this type of exposure? _____%	
<input type="checkbox"/> Pregnancy Care	Pregnancy management and care into Second Trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pregnancy management and care into Third Trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Weight Control / Bariatrics	Any type of Weight Control and/or Bariatric Surgeries? If yes, you <u>must</u> provide details on a separate page.	
	Do you <input type="checkbox"/> dispense and/or <input type="checkbox"/> prescribe any weight control drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If Yes, list drug types and provide practice protocols in Comments section or separate page.	
	What percentage of your practice is devoted to this type of exposure? _____%	

IV. MEDICALLY RELATED PERSONNEL

Do you employ, contract with, or supervise any Medical Personnel? Yes No

If YES, enter information below:

TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY	TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY
Midwife			Medical Lab Technician		
CRNA			Pharmacist		
Nurse Practitioner			Nurse (RN/LPN)		
Physician Assistant			X-Ray Technician		
Surgeon Assistant			Physical Therapist		
Optometrists			Surgeon		
Physician					

OTHER (Please provide detail on separate page)

V. CHANGES in PRACTICE

HAVE YOU MADE ANY CHANGE WITHIN THE PAST TWELVE (12) MONTHS IN ANY OF THE FOLLOWING? (If yes, provide details on a separate page.)

1. Advertising; materials, types, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Board Certification; Status change	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Business Location(s); additions or deletions	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Continuing Medical Education	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Contractual Arrangements; additions or deletions	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Medical Association/Society Membership; status change	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Partnerships/Corporations/Association; changes, additions or deletions	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Procedures Performed; added or discontinued	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Specialty; modified, added, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Other, specify	<input type="checkbox"/> Yes <input type="checkbox"/> No

VI. PRIOR POLICY AND LOSS INFORMATION UPDATES

1. Has your medical or narcotics license been suspended, denied, revoked, restricted, or is currently under review of investigation by any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been diagnosed with or treated for, alcoholism, drug addiction, a mental or chronic physical illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been indicted or charged in a criminal suit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have your hospital privileges been suspended, denied, revoked, restricted or placed in probationary status?	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Have any fee or professional relations complaints been alleged against you with your medical association(s), hospital(s) or any state licensing authority?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have any claims been made against you, suit papers served upon you, or any other demands for money resulting from a medical incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "Yes", have these been reported to and acknowledged by GENERAL STAR ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If "Yes", have these been reported to any other current or prior insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services that might reasonably result in a claim, that have not been reported to GENERAL STAR or a prior insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", a CLAIM INFORMATION SUPPLEMENT <u>must</u> be completed for each incident referenced.	
<ul style="list-style-type: none"> ▶ When facts or circumstances that relate to a medical incident(s) that might reasonably result in a claim are disclosed in response to this question and any accompanying Claim Information Supplement, there will not be coverage for any claims made against you arising from those facts or circumstances under any General Star policy that becomes effective after the date of the disclosure. ▶ The disclosure of facts or circumstances that relate to medical incident(s) that might reasonably result in a claim in response to this question or in any accompanying Claim Information Supplement DOES NOT constitute notice to General Star for claim reporting purposes under your current General Star policy. ▶ In order to report a claim, the reporting requirements in your current General Star policy must be followed. Please review your current policy for claim or incident reporting requirements. 	
8. Has any prior claim(s) been adjudicated, settled, closed, dismissed or otherwise changed in status? If Yes, please complete a CLAIM INFORMATION SUPPLEMENT.	<input type="checkbox"/> Yes <input type="checkbox"/> No

VII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and
2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):

<input type="checkbox"/> Substance Impairment Supplemental Application	<input type="checkbox"/> Correctional Facility Supplemental Application
<input type="checkbox"/> Bariatric Surgery Supplemental Application	<input type="checkbox"/> Statement of No Known Claims Letter
<input type="checkbox"/> Claim Information Supplemental Application	<input type="checkbox"/> Other _____
3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:
 - a. Accurate, true and complete to the best of your knowledge;
 - b. No material facts have been suppressed or misstated;
 - c. Representations you are making on behalf of all persons and entities proposed to be insured;
 - d. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.

4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.
5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

NEW YORK FRAUD WARNING: 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING (not applicable in Nebraska, Vermont or Virginia): Any person who knowingly and with the 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where General Star National Insurance Company is "non-admitted or "surplus lines"), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

Signature of Applicant

Date

Print or Type Name and Title