



APPLICATION FOR CLAIMS MADE AND REPORTED FORM OF POLICY FOR PHYSICIANS AND ORAL/MAXILLOFACIAL SURGEONS

- SCPIE Indemnity Company
- American Healthcare Indemnity Company
- American Healthcare Specialty Insurance Company

**IMPORTANT
PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION****INSTRUCTIONS:****SIGNATURE**

Your signature and the date are required on Page 16. You must answer each question. **INCOMPLETE APPLICATIONS MAY BE SUBJECT TO DECLINATION.**

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, PAGE 14. Claims will be reviewed by Underwriting. Please provide sufficient information for the underwriters to evaluate the medical aspects of the case, specifically relating to the treatment which you rendered. Each Claim Information sheet completed must be signed and dated.

PROFESSIONAL MEDICAL/DENTAL PARTNERSHIPS OR CORPORATIONS WITH MORE THAN ONE PARTNER/SHAREHOLDER

If you are practicing in a professional medical/dental partnership or corporation with more than one partner/shareholder, it will be necessary for the entity to complete an application for Physician Coverage. Please contact your SCPIE Companies agent to obtain this form.

IT IS THE POLICY OF THE SCPIE COMPANIES NOT TO PROVIDE INSURANCE COVERAGE TO ANY PHYSICIAN WHOSE PRIMARY PRACTICE IS ASSOCIATED WITH ONE OR MORE ADDITIONAL PHYSICIANS AS AN EMPLOYEE, A PARTNER, OR A SHAREHOLDER UNLESS ALL SUCH PHYSICIANS ARE INSURED BY THE SCPIE COMPANIES.

EFFECTIVE DATE - APPROVAL NOTICE - INITIAL BILLING

Your application is subject to underwriting review and approval by The SCPIE Companies. Upon approval of your application by The SCPIE Companies, you will receive an approval letter and your first billing will be forwarded to you shortly thereafter. The effective date of this coverage is subject to approval by The SCPIE Companies, in no event will coverage be effective prior to the date this application was received and date-stamped by The SCPIE Companies. If the application is hand-carried or received by facsimile, the effective date of coverage will be no earlier than the following day.

RETROACTIVE (“NOSE”) COVERAGE

“Nose” coverage provides coverage for claims first made against the physician after the effective date of coverage with The SCPIE Companies, arising out of the physician’s acts or omissions prior to the effective date and after the retroactive date of such coverage. If the physician does not obtain “Nose” coverage, the physician will have no coverage from The SCPIE Companies for such claims arising out of these acts or omissions. “Nose” coverage is subject to underwriting approval. **IF THE PHYSICIAN DESIRES TO OBTAIN “NOSE COVERAGE,” A COPY OF THE PHYSICIAN’S MOST RECENT DECLARATIONS PAGE FROM THE PRESENT CARRIER INDICATING THE ORIGINAL EFFECTIVE DATE OF COVERAGE AND A CURRENT PAID THROUGH DATE MUST BE ATTACHED.**

AGENCY/BROKERAGE INFORMATION			
Agency/Brokerage Name	United Agencies, Inc.		
Agent/Broker Name	Dana Justin Coates		
Agent/Broker	License Number 0529163		
Address	525 Cordova St., Suite 200		
City	Pasadena	State CA	Zip 91101-2552
Phone No. (800) 378-5554 x 205	Fax No. (626) 628-3792		
E-Mail Address	dcoates@unitedagencies.com		

**THE SCPIE COMPANIES
APPLICATION FOR CLAIMS MADE POLICY FORM
FOR PHYSICIANS AND ORAL/MAXILLOFACIAL SURGEONS**

The undersigned hereby applies to THE SCPIE COMPANIES (the Company) for Professional Liability Insurance coverage according to the terms and conditions of its policy of Physicians Professional Liability Insurance Claims Made Form, SIE -30, or CPP-90, a copy of which I have received and examined.

If I am practicing (i) as an individual practitioner (ii) as the sole shareholder of a professional medical/dental corporation or (iii) as an employee of an individual practitioner or a solo professional medical/dental corporation, I am hereby applying to become the "named insured physician" under a policy to be issued by the Company. If I am practicing (i) as a member or employee of a professional medical/dental partnership or (ii) as a shareholder, employee, officer, or director of a professional medical/dental corporation which may have more than one shareholder, I am applying hereby to become a "physician member" under a policy issued or to be issued by the Company to such partnership or corporation as the "named insured."

I UNDERSTAND THAT THE PROFESSIONAL LIABILITY, PROFESSIONAL COMMITTEE ACTIVITIES, OFFICE PREMISES LIABILITY INSURANCE AND LEGAL DEFENSE REIMBURSEMENT FOR STATE LICENSING AUTHORITY PROCEEDINGS UNDER THE INDIVIDUAL PRACTITIONER POLICY SIE-30 AND THE MEDICAL PARTNERSHIP OR CORPORATION POLICY IS "CLAIMS MADE AND REPORTED" COVERAGE AND THAT THESE POLICIES DO NOT PROVIDE COVERAGE FOR ANY CLAIMS WHICH ARE FIRST REPORTED TO THE COMPANY AFTER TERMINATION OF THE "COVERAGE PERIOD" AS DEFINED BY THE POLICIES.

IF APPLYING AS A PHYSICIAN MEMBER UNDER THE PROFESSIONAL AND BUSINESS LIABILITY INSURANCE POLICY FOR MEDICAL GROUPS AND CLINICS, CPP-90, I UNDERSTAND THAT THE PROFESSIONAL LIABILITY AND LEGAL DEFENSE REIMBURSEMENT FOR STATE LICENSING AUTHORITY PROCEEDINGS ONLY IS "CLAIMS MADE AND REPORTED" COVERAGE AND THAT THE POLICY DOES NOT PROVIDE COVERAGE FOR THOSE CLAIMS AGAINST A PHYSICIAN MEMBER (FOR HIS OR HER ACTS OR OMISSIONS) WHICH ARE FIRST REPORTED TO THE COMPANY AFTER TERMINATION OF THE PHYSICIAN MEMBERS' "CERTIFICATE PERIOD" AS DEFINED IN THE POLICY.

I further understand that, unless I obtain retroactive "Nose" coverage from the Company, the policy does not provide coverage for claims reported to the Company during the coverage period relating to or arising out of incidents occurring prior to the effective date of the coverage. THIS INSURANCE IS AVAILABLE ONLY TO LICENSED PHYSICIANS AND ORAL/MAXILLOFACIAL SURGEONS.

OFFICE USE ONLY

Account No. _____

Policy No. _____

Group No. _____

Renewal Application

New Application

DATE RECEIVED

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 _____

Note: The effective date of this coverage is the earliest date this application was received and date-stamped by the Company. If the application is hand-carried or received by facsimile or other electronic means, the earliest effective date of coverage is the following day. All effective dates are subject to underwriting approval.

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 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 Company for claims arising out of these acts or omissions.

THE COMPANY MAY NOT PROVIDE RETROACTIVE (“NOSE”) COVERAGE TO PHYSICIANS WHOSE PRIOR PRACTICES WERE LOCATED IN OTHER STATES.

- a. I am applying for retroactive (“Nose”) coverage: 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:

	INSURANCE CARRIER(S)	POLICY NUMBER(S)	POLICY PERIOD(S)	
			From	To
i.	_____	_____	____/____/____	____/____/____
ii.	_____	_____	____/____/____	____/____/____
iii.	_____	_____	____/____/____	____/____/____

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.

MEDICAL SPECIALTIES	INSURANCE CARRIER(S)	POLICY PERIOD(S)	
		From	To
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

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

- * a. Is there documented communication between the Hospitalist and the attending/primary care physician? Yes No
IF NO, PROVIDE EXPLANATION IN THE REMARKS SECTION, PAGE 13.
- b. Does the Hospitalist cover ER or do on-call for ER? Yes No
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.

- a. Hospital Surgery as Primary Surgeon Yes No
- b. Assisting in Surgery Only Yes No
- c. Office Surgery ³ Yes No
- d. Surgery in Surgicenter ³ Yes No
- e. Obstetrics Yes No
- f. Therapeutic Abortions Yes No
Number performed monthly _____
- g. Amniocentesis Yes No
- h. Cosmetic/Plastic Surgery
 - i. Minor ³ Yes No
 - ii. Major Yes No
 - iii. Chemical Peels ³ Yes No
 - iv. Hair Transplants Yes No
 - v. Radiation Therapy Yes No
 - vi. Scar Revisions Yes No
 - vii. Sclerotherapy Yes No
 - viii. Silicone Injections Yes No
 - ix. Suction Lipectomy ^{3 & 4} Yes No
- i. Fracture Reductions
 - i. Open Yes No
 - ii. Closed Yes No
- j. Cardiac Catheterization
 - i. Right Heart Yes No
 - ii. Left Heart Yes No
- k. Anesthesia
 - i. General Yes No
 - ii. Nerve Block Yes No
 - iii. Spinal/Caudal Yes No
 - iv. Local Yes No

- l. Laser Refractive Surgery Yes No
- m. Blepharopigmentation Yes No
- n. X-Ray
 - i. Diagnostic Yes No
 - ii. Therapeutic Radiation Yes No
 - iii. Ultrasound Yes No
- o. Coronary Angiography Yes No
- p. Cerebral Angiography Yes No
- q. Renal Dialysis Yes No
- r. Electroconvulsive Therapy Yes No
- s. Endoscopy Yes No
- t. Sigmoidoscopy Yes No
- u. Spinal Surgery Yes No
- v. Weight Control
 - i. Surgery ³ Yes No
 - ii. Drugs - List Below Yes No

- iii. Percentage of Practice _____ %
- w. Laser Procedures ^{3 & 4} Yes No

- x. Other ³ Yes No

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 _____
- 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 ___/___/___
- 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 CO₂ 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 of this application.

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 | • Group | • Clinic | • County/University |
| • Your DBA (if any) | • Partnership | • Public or Private Entity | • Federal Government |
| • Another Physician’s DBA | • Corporation | • HMO | • 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 _____ Contracting Relationship
 Employment Relationship

His/Her Name _____ Carrier _____ Contracting Relationship
 Employment Relationship

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

Name	Title	Salaried Employee	Independent Contractor
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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	_____

Please indicate your relationship to the primary practice location. (Check all that apply)

Individual Practitioner
 Solo Medical Corporations
 Independent Contractor
 Salaried Employee
 Officer/Director/Shareholder of Medical Corp (Not Solo)
List Owners in Remarks Section
 Partner in a Medical Partnership
List Owners in Remarks Section
 Other, please describe:

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

Please indicate your relationship to the primary practice location. (Check all that apply)

- Individual Practitioner
- Solo Medical Corporations
- Independent Contractor
- Salaried Employee
- Officer/Director/Shareholder of Medical Corp (Not Solo)
List Owners in Remarks Section
- Partner in a Medical Partnership
List Owners in Remarks Section
- Other, please describe: _____

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 _____ Contracting Relationship
 Employment Relationship

His/Her Name _____ Carrier _____ Contracting Relationship
 Employment Relationship

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
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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

Please indicate your relationship to the primary practice location. (Check all that apply)

- Individual Practitioner
- Solo Medical Corporations
- Independent Contractor
- Salaried Employee
- Officer/Director/Shareholder of Medical Corp (Not Solo)
List Owners in Remarks Section
- Partner in a Medical Partnership
List Owners in Remarks Section
- Other, please describe:

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 _____ Contracting Relationship
 Employment Relationship

His/Her Name _____ Carrier _____ Contracting Relationship
 Employment Relationship

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

Name	Title	Salaried Employee	Independent Contractor
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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.

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

_____ to _____
 Type of Practice (i.e., Medical Group, HMO) Address City State Zip

b. _____ to _____
 Name of Practice Month/Year Month/Year

_____ to _____
 Type of Practice (i.e., Medical Group, HMO) Address City State Zip

c. _____ to _____
 Name of Practice Month/Year Month/Year

_____ to _____
 Type of Practice (i.e., Medical Group, HMO) Address City State Zip

d. _____ to _____
 Name of Practice Month/Year Month/Year

_____ to _____
 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 the Company?

- Medical Association/Society Physician Colleague Mailing
 Advertisement Presentation by a Company Representative
 Other _____

33. My decision to apply to the Company 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 VIII — OPTIONAL EXCESS PERSONAL LIABILITY COVERAGE (\$1,000,000 Per Occurrence)

This coverage provides personal liability protection for claims arising out of personal injury or property damage occurring during the insured's policy period or coverage period. This coverage is excess over and above the required underlying limits listed below, and does not apply to personal injury or property damage claims arising out of business or professional pursuits of the insured.

35. Do you desire this coverage? Yes No

IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

a. Do you maintain the following minimum limits of liability on underlying policies? Yes No

IF NO, YOU MUST INCREASE YOUR LIMITS TO THOSE INDICATED BELOW BEFORE COVERAGE MAY BE ADDED.

i. AUTOMOBILE LIABILITY: \$100,000/\$300,000 Bodily Injury \$25,000 Property Damage or Combined Single Limit of \$300,000 Yes No

ii. COMPREHENSIVE PERSONAL LIABILITY: \$50,000 (Often found in Section II of Homeowner's Policy) Yes No

iii. Do you own, lease, rent, or regularly use watercraft twenty-six feet (26') or more in length? Yes No

IF YES, DO YOU MAINTAIN \$100,000 WATERCRAFT LIABILITY COVERAGE? Yes No

b. During the past three years, has any insurance company canceled, declined coverage, or refused renewal of any similar Excess Personal Liability Insurance? Yes No

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)**

I understand information submitted herein becomes part of the Physician's Professional Liability Application as submitted.

Date _____ Signed _____

SECTION XI — SIGNATURE

THIS IS THE SIGNATURE SECTION TO THE APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE FOR ALL PHYSICIANS AND ORAL/MAXILLOFACIAL SURGEONS.

REPRESENTATIONS AND AUTHORIZATIONS OF APPLICANT

I UNDERSTAND THAT IT IS THE POLICY OF THE COMPANY GENERALLY NOT TO PROVIDE INSURANCE COVERAGE TO ANY PHYSICIAN WHO IS ASSOCIATED WITH ONE OR MORE ADDITIONAL PHYSICIANS AS A MEMBER OF A PROFESSIONAL MEDICAL/DENTAL PARTNERSHIP OR CORPORATION OR AS AN EMPLOYER OR EMPLOYEE OF SUCH PHYSICIAN, UNLESS ALL SUCH PHYSICIANS ARE INSURED BY THE COMPANY OR ARE CURRENTLY FILING APPLICATIONS FOR INSURANCE WITH THE COMPANY. I FURTHER UNDERSTAND THAT ANY INSURANCE COVERAGE PROVIDED TO ME BY THE COMPANY IS SUBJECT TO CANCELLATION IN THE EVENT ANY PHYSICIAN WITH WHOM I AM OR BECOME ASSOCIATED, AS A MEMBER OF A PROFESSIONAL ASSOCIATION, MEDICAL/DENTAL PARTNERSHIP OR CORPORATION, OR AS AN EMPLOYER OR EMPLOYEE OF SUCH PHYSICIAN, IS NOT OR CEASES TO BE AN INSURED BY THE COMPANY.

Note: The Company, in certain instances, will issue policies to individual insured physicians who are associated with physicians in a professional medical/dental partnership or corporation in which all of the other physicians are not insured by the Company or when a physician employer or employee of the insured is not insured by the Company. Physicians are cautioned that there is no coverage under such policies for acts or omissions of the physicians not insured by the Company.

I authorize the release and exchange of information involving past and future underwriting and claims matters between the Company and my present and any past professional associations/societies, the county medical association/society in any county in which I practice(d), their committees and insurance consultants, any hospital with which I presently or previously held staff privileges, any prior insurance companies and any state medical licensing board or other governmental agency. I authorize the Company to forward Evidence of Insurance to the hospitals listed in response to Question 29. and the Emergency Departments/Hospitals/Health Plans who provide my signed authorization to do so in the future.

I agree that the Company and, to the extent requested by the Company and/or any other authorized representatives of the Company, may participate in the processing and review of this application, of any future information submitted and of any matter relating to any incidents or claims of alleged medical malpractice while I am insured by the Company.

I also agree that if requested by the Company, I will promptly submit a Request for Information Disclosure form to The National Practitioner Data Bank requesting a Self-Query, and will forward the full results of such query to the Company immediately upon my receipt thereof for inclusion in this application for insurance.

If I become a physician member under a policy issued by the Company to a partnership or corporation (as "named insured"), I irrevocably authorize and designate the medical/dental partnership or medical corporation, if any, of which I am a member, officer, director or employee to act on my behalf and as my agent in all respects (including, without limitations, the payment of premiums, and the receipt of refunds thereof, and the receiving and giving of notices of all types) relating to the insurance for which I am applying. This authorization and designation shall remain in effect for so long as such partnership or corporation is a named insured under an insurance policy issued by the Company and I am a certificate holder under such policy.

I HEREBY REPRESENT THAT THE STATEMENTS AND ANSWERS MADE WITHIN THIS APPLICATION ARE FULL, COMPLETE AND TRUE. ALSO, I UNDERSTAND THAT THIS IS NOT A BINDER OF INSURANCE, BUT IS INSTEAD AN APPLICATION FOR INSURANCE, AND THAT IT IS SUBJECT TO UNDERWRITING REVIEW AND APPROVAL.

NOTE: THE FOLLOWING TWO (2) PARAGRAPHS APPLY TO SCPIE INDEMNITY COMPANY APPLICANTS ONLY.

It is the policy of SCPIE Indemnity Company that all of its insurance policies expire each year on January 1 at 12:01 a.m. and that changes in premiums and other policy terms are generally made at that time. If a policy is first issued after the first day of a calendar year, such changes in premium terms may be made at the following January 1 only if the insured requests a policy term of less than one (1) year.

APPLICANT HEREBY REQUESTS THAT SCPIE INDEMNITY COMPANY ISSUE THE POLICY FOR A TERM EXPIRING AT 12:01 A.M. ON JANUARY 1 NEXT FOLLOWING THE DATE OF THIS APPLICATION. APPLICANT UNDERSTANDS THAT PREMIUMS WILL BE PAYABLE QUARTERLY.

Name of Applicant (Please type or print name)

Signature of Applicant (Please sign your name)

Address

City

State

Zip

Date

STATE FRAUD NOTICES

Notice To Arkansas Applicants

“Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

Notice To California Applicants

“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.”

Notice To Colorado Applicants

“It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within The Department of Regulatory Agencies.”

Notice To District of Columbia Applicants

“Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.”

Notice To Florida Applicants

“Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.”

Notice To Kentucky Applicants

“Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance 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.”

Notice To Maine Applicants

“It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.”

Notice To New Jersey Applicants

“Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.”

Notice To New Mexico Applicants

“Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.”

Notice To New York Applicants

“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 (\$5,000) and the stated value of the claim for each such violation.”

Notice To Ohio Applicants

“Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.”

Notice To Oregon Applicants

“Any person who knowingly, and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.”

Notice To Virginia Applicants

“It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”