



ProNational[®]

INSURANCE COMPANY

A ProAssurance Company

Medical Professional Liability Insurance Application Form

With your fully completed, signed and dated application, you **must** submit the following information:

1. Current insurance policy declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Articles of Incorporation, if applicable.
5. Loss runs from all prior insurance companies or explanation as to why they are not available.
6. Copy of curriculum vitae.

Note: Submission of a completed application confers no obligation upon the Company to bind coverage.

ProNational Insurance Company
P.O. Box 150
Okemos, Michigan 48805-0150
517/349-6500 800/292-1036

5. Professional Liability Insurance History

Name of Company (Current)	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
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Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence

A. Have you ever applied to Mutual Assurance, Medical Assurance, ProNational or Red Mountain Casualty for insurance before? Yes No

B. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage? Yes No

If yes, requested retroactive date: _____

Important: If you are not applying for prior acts coverage and are not purchasing a reporting endorsement from your current carrier, please explain why on pages 17-18 and/or a separate sheet.

C. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes No

Important: If you answered yes, to question 5C, please submit a **complete explanation** using pages 17-18 and/or a separate sheet of paper.

Important information regarding questions 5D and 5E (including sub-questions):

1. The word "claim" as used in Questions 5D and 5E following refers to:
 - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer yes to questions 5D through 5E (including sub-questions), please complete the attached Supplementary Claims Information Form (page 19).

D. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? Yes No
If yes, indicate how many. _____

E. Other than the claims/suits indicated in 5D above, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

- i. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
- ii. A letter from an attorney regarding your medical treatment of a patient? Yes No
- iii. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability or the need for follow-up surgery? Yes No
- iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes No
- v. Any other circumstances that might reasonably lead to a claim or suit? Yes No
- vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? N/A* Yes No
 - a. If yes, how many? _____ Please attach documentation of all such reports.
 - b. If no, please explain on pages 17-18.

* For purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.

Important: If you answer yes, to questions 5F through 5O, please provide details on page 17-18, and/or a separate sheet.

F. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? Yes No

G. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? Yes No

H. Have you ever failed any licensing or Board Certification examinations? Yes No
If yes, how many times? _____

- I. Have you ever been refused hospital privileges? Yes No
- J. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee?..... Yes No
- K. Have you ever had a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee?..... Yes No
- L. Have you ever been convicted of or pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance?..... Yes No
- M. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? Yes No
- N. Have you ever been accused of sexual misconduct of any kind? Yes No
- O. Do you have any physical handicap or any chronic illness? Yes No
- P. Do you perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? Yes No
- i. If yes, please indicate all states in which the patients being treated reside:

- ii. What percentage of your total practice does telemedicine constitute? _____%
- Q. Do you read, interpret or diagnose films, slides or specimens taken from patients who reside in states other than your indicated state of practice? Yes No
- If yes, indicate all states in which the patients being treated reside:

- R. Are you employed full-time or part-time by the Federal, State, or Local Government? ... Yes No
- If yes, explain the nature of such employment on pages 17-18 and/or additional sheets.
- i. Are you on active duty in the U.S. Military Service? Yes No
- ii. Are you a resident, intern or fellow? Yes No
- S. If the answer to 5R, 5Ri, or 5Rii above is yes, are you engaged in or planning to engage in any "moonlighting" activity? Yes No
- If yes, do you wish coverage for your "moonlighting" activities? Yes No
- Important:** If yes, describe the nature of your "moonlighting" activities on pages 17-18 and/or a separate sheet.
- T. Will you read your own X-rays? Yes No
- i. If yes, will they subsequently be read by a radiologist? Yes No
- ii. If yes, how soon? Within _____ hours.
- U. Are you ACLS or ATLS certified? Yes No
- V. Do you now or have you ever provided services to any state, local or federal correctional facility, jail or prison? Yes No

W. Do you, or will you, staff an emergency room? Yes No

i. If yes, how many hours per week? _____

ii. If yes, in which hospital(s) or for what staffing company will you work?

iii. Is this emergency room practice required for staff privileges? Yes No

iv. Will specialists be available at the hospital or on call during your shift to provide backup for you? Yes No

v. If yes, please list available or on-call specialists below. Use pages 17-18 and/or a separate sheet if additional space is needed.

X. Do you practice any of the following forms of "Alternative Medicine"?

i. Ayurvedic Medicine Yes No

ii. Chiropractic Medicine Yes No

iii. Chinese Medicine Yes No

iv. Holistic Medicine Yes No

v. Homeopathic Medicine Yes No

vi. Naturopathic Medicine Yes No

vii. If you answered yes, to any of the above, are you a member of:

A.A.N.P. Yes No

A.C.A.M. Yes No

Diplomat candidate Yes No

Diplomat Yes No

Follower of protocol Yes No

Y. Are you a sports team physician for any college, university, semi-professional or professional team? Yes No

If yes, please explain.

Premium Classification – Please check any of the following that apply to you practice:

- | | | |
|---|--|--|
| <input type="checkbox"/> Elective Abortions
<input type="checkbox"/> Prescribe Preven, or related derivatives
<input type="checkbox"/> Prescribe Mifepristone, or related derivatives in combination with cytotec? | <input type="checkbox"/> Dermopathology
<input type="checkbox"/> Echocardiography
<input type="checkbox"/> Electrocardiography
<input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Pain Management
<input type="checkbox"/> Medication Only
<input type="checkbox"/> Facet Blocks
<input type="checkbox"/> Selective Nerve Root Blocks |
| <input type="checkbox"/> Acupuncture
<input type="checkbox"/> Anesthesia
<input type="checkbox"/> Spinal
<input type="checkbox"/> Caudal
<input type="checkbox"/> General
<input type="checkbox"/> Local

<input type="checkbox"/> Other _____ | <input type="checkbox"/> Encephalography
<input type="checkbox"/> Endoscopic Laser Therapy
<input type="checkbox"/> Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy
<input type="checkbox"/> ERCP / EGD / ERC
<input type="checkbox"/> Exchange Transfusions in Newborns
How many per year? _____ | <input type="checkbox"/> Rhizotomy
<input type="checkbox"/> Spinal Injections
<input type="checkbox"/> Dorsal Root Gangliotomies
<input type="checkbox"/> Thoracic Sympathectomies
<input type="checkbox"/> Spinal Cord Stimulators |
| <input type="checkbox"/> Angiography
<input type="checkbox"/> Angioplasty
<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Arteriography
<input type="checkbox"/> Arthroscopy
<input type="checkbox"/> Assist in Major Surgery
<input type="checkbox"/> On patients of others
<input type="checkbox"/> On own patients | <input type="checkbox"/> Fertility Treatment
<input type="checkbox"/> Fluoroscopy
<input type="checkbox"/> Fracture Reductions
<input type="checkbox"/> Open
<input type="checkbox"/> Closed | <input type="checkbox"/> Implantation/Removal of Drug Infused Pumps
<input type="checkbox"/> Sphenopalatine Lesioning
<input type="checkbox"/> Trigeminal Lesioning
<input type="checkbox"/> Cordotomies
<input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bariatric Surgery
<input type="checkbox"/> Blepharoplasty
<input type="checkbox"/> Breast Biopsy
<input type="checkbox"/> Breast Implants
<input type="checkbox"/> Cosmetic
_____ % of practice
<input type="checkbox"/> Reconstructive
_____ % of practice | <input type="checkbox"/> Gastroscopy
<input type="checkbox"/> General – major surgery
<input type="checkbox"/> Gynecology – major surgery
<input type="checkbox"/> Hand – major surgery
<input type="checkbox"/> Head and Neck – major surgery
<input type="checkbox"/> Hemorrhoidectomy
<input type="checkbox"/> Hernia Repair
<input type="checkbox"/> Hip Nailings
<input type="checkbox"/> Hyperbaric Medicine
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Hysteroscopy
<input type="checkbox"/> Intensive care for newborns within a Tertiary Care Unit | <input type="checkbox"/> Pedicle Screws for Spinal Surgery
<input type="checkbox"/> Percutaneous Vertebroplasty
<input type="checkbox"/> Permanent Pacemaker
<input type="checkbox"/> Plastic – major surgery
<input type="checkbox"/> Polypectomy
<input type="checkbox"/> Prenatal Care
<input type="checkbox"/> Prolotherapy
<input type="checkbox"/> Radiation/X-ray Therapy
<input type="checkbox"/> Radiopaque Dye
<input type="checkbox"/> Rhinology – major surgery
<input type="checkbox"/> Roux-en-y
<input type="checkbox"/> Sclerotherapy
<input type="checkbox"/> Scoliosis Surgery
<input type="checkbox"/> Shock Therapy
<input type="checkbox"/> Sterilization Procedures
<input type="checkbox"/> Thoracic Surgery _____ % |
| <input type="checkbox"/> Bronchoscopy
<input type="checkbox"/> Cardiac – major surgery
<input type="checkbox"/> Cardiovascular Disease – major surgery
<input type="checkbox"/> Chelation therapy (for other than heavy metal poisoning)
<input type="checkbox"/> Chemonucleolysis
<input type="checkbox"/> Cholecystectomy
<input type="checkbox"/> Cholecystectomy, Laparoscopic
<input type="checkbox"/> Circumcision (other than newborns) | <input type="checkbox"/> Laminectomy
<input type="checkbox"/> Laparoscopy
<input type="checkbox"/> Laryngology – major surgery
<input type="checkbox"/> Laser Surgery
<input type="checkbox"/> Left Heart Catheterization
<input type="checkbox"/> Liposuction
<input type="checkbox"/> Lithotripsy
<input type="checkbox"/> Lumbar Fusion
<input type="checkbox"/> Mammography | <input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Tonsillectomy/Adenoidectomy
<input type="checkbox"/> Transgender Surgery and/or Hormonal Gender Conversion
<input type="checkbox"/> Trigger Point Injections
<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Urology – major surgery
<input type="checkbox"/> Vascular Surgery _____ %
<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Weight Control _____ % |
| <input type="checkbox"/> Colon and Rectal – major surgery
<input type="checkbox"/> Colonoscopy
<input type="checkbox"/> Colposcopy
<input type="checkbox"/> Cryosurgery (other than external lesions)
<input type="checkbox"/> Dermatological Surgery
<input type="checkbox"/> Chemical peels
<input type="checkbox"/> Chemobrasion
<input type="checkbox"/> Collagen Injections
<input type="checkbox"/> Cryosurgery (superficial only)
<input type="checkbox"/> Dermabrasion
<input type="checkbox"/> Eye Liner Pigmentation
<input type="checkbox"/> Fat Transfer
<input type="checkbox"/> Hair Transplants
<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Laser Skin Resurfacing
<input type="checkbox"/> Microdermabrasion
<input type="checkbox"/> Silicone Injections
<input type="checkbox"/> Tumescant Liposuction
<input type="checkbox"/> Other
_____ | <input type="checkbox"/> Myelography
<input type="checkbox"/> Myomectomy
<input type="checkbox"/> Neonatology
<input type="checkbox"/> Neurology – major surgery
<input type="checkbox"/> Norplant Insertion/Extraction
<input type="checkbox"/> Obstetrics/Gynecology – major surgery
<input type="checkbox"/> Normal Deliveries
<input type="checkbox"/> C-Sections
<input type="checkbox"/> VBAC
By Induction? <input type="checkbox"/> Y <input type="checkbox"/> N
Induction agent: _____ | <input type="checkbox"/> None of the above apply to my practice. _____
(Please Initial)
<input type="checkbox"/> Other Procedures (List):

_____ |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Ophthalmology – major surgery
<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Orthopedic – major surgery
<input type="checkbox"/> Spines
<input type="checkbox"/> No Spines
<input type="checkbox"/> Osteopathic Manipulative Medicine
<input type="checkbox"/> Otology – major surgery
<input type="checkbox"/> Otorhinolaryngology – major surgery
<input type="checkbox"/> Including elective cosmetic procedures
<input type="checkbox"/> Not including elective cosmetic procedures | |

If you are applying for coverage for an obstetrical practice, do you have privileges to perform C-sections at each hospital you staff? Yes No
Important: If "no", please provide full details of your back-up arrangements on pages 17-18 and/or a separate sheet.

If applicant is approved for coverage it will be his/her responsibility to notify the Company of any changes in practice specialty, including but not limited to practice location, procedures, affiliation, etc. Failure to notify the Company of such changes could require retroactive upward premium adjustment and in the event of a claim could lead to a denial of coverage.

6. Rating Information

- A. What is your present specialty? _____
- B. What is your present sub-specialty? _____
- C. What percentage of your practice is devoted to your specialty? _____%
- D. What percentage is devoted to your sub-specialty? _____%
- E. Have there been any changes in your specialty, classification or practice activity within the past ten years? Yes No

Important: If yes, describe the nature of changes in specialty, classification or practice activities on pages 17-18 and/or a separate sheet.

- F. Are you American Board Certified? Yes No
 - i. If yes, to 6F, please list Specialty Board: _____ (Indicate osteopathic or allopathic.)
 - ii. If yes, to 6F, please list date of Board Certification: _____

Month
Day
Year
 - iii. If no, to 6F, are you Board eligible? Yes No
 - iv. If Board eligible, when do you plan to take your Boards? _____
- G. Indicate the average number of: Patients seen per week: _____ Hours practiced per week*: _____
 (*Including on-call hours)
- H. If applying for obstetrical coverage, indicate:
 - i. average number of deliveries per year _____,
 - ii. percentage of high risk deliveries _____%, and
 - iii. average number of VBAC deliveries per year _____.
- I. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by/responsible to an anesthesiologist? Yes No
 If yes, explain the nature and percentage of your surgery or the average number of cases per month: _____

7. Managed Care Contract Information

Name of Managed Care Organization	Approximate % of Total Patients	Capitated	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>

8. Educational Information

Name of Medical School(s) Attended	Location of Medical School(s) Attended	Degree	Date Graduated

If you are a foreign medical school graduate, have you ever failed the examination Education Council for Foreign Medical School Graduates? Yes No
 If yes, how many times? _____

Residencies, Internships, Fellowships, Preceptorships					
Hospital Data		Specialty and/or Department	Dates (Month/Year)		Completed?
Name	Location		Start	End	
Internship					Yes <input type="checkbox"/> No <input type="checkbox"/> *
					Yes <input type="checkbox"/> No <input type="checkbox"/> *
Residency					Yes <input type="checkbox"/> No <input type="checkbox"/> *
					Yes <input type="checkbox"/> No <input type="checkbox"/> *
Fellowship					Yes <input type="checkbox"/> No <input type="checkbox"/> *
					Yes <input type="checkbox"/> No <input type="checkbox"/> *
Other: specify					Yes <input type="checkbox"/> No <input type="checkbox"/> *

*** If you answered no, explain fully on pages 17-18 and/or a separate sheet**

Other Medical Education (Category I Continuing Medical Education Programs) Completed in the Past Three Years		
Courses Completed	CME Credits Received	Date(s) Attended Month/Year

9. Practice History

Please list locations where you have practiced since residency training.

Location	Dates (Month/Year)*	
	Start	End
* Provide brief description of each practice situation, including clinical responsibilities, and explain any gaps in practice on pages 17-18 and/or a separate sheet.		

10. Hospital Affiliations and Privileges

A. Please list hospitals where you have, or have had active privileges.

Hospital Data			Dates (Month/Year)		Percentage of Your Patients Admitted to This Facility
Name	Location (City & State)	Department	Start	End	

B. Please list hospitals where you have applied for privileges but have not yet been accepted.

Hospital Data			Dates (Month/Year)		Percentage of Your Patients to be Admitted to This Facility
Name	Location (City & State)	Department	Start	End	

C. Please list hospitals where you have been denied privileges.*

Hospital Data			Date Denied (Month/Year)
Name	Location (City & State)	Department	

***Explain any denial of privileges on pages 17-18 and/or a separate sheet.**

11. Practice Organization

A. Coverage is desired for: (check all that apply)

- Solo Entity: Name _____ Shared Limits Only*
Corp. Tax ID # _____ Date of Incorporation _____
- Member of a partnership or multi-shareholder corporation:
Partnership/Group Name _____ Separate Limits
Corp. Tax ID # _____ Date of Incorporation _____ Shared Limits*
- Other (i.e., implied partnership, corporation, etc.):
Entity Name _____ Separate Limits
Corp. Tax ID # _____ Date of Incorporation _____ Shared Limits*

* Shared limits are not permitted in Pennsylvania and on a very limited basis in Wisconsin

Please include Articles of Incorporation, accompanied by a list of principals, and a copy of your business letterhead.

- B. Give the full names of all other physicians affiliated with any organization(s) named in Question 11A. **All affiliated physicians must complete a separate application if organization coverage is to be provided. Use Pages 17-18 and/or additional sheets if needed.**

Name	Current Medical Professional Liability Insurance Co.

12. Information on Allied Health Care Professionals

The following is a list of “allied health care professionals” for which a separate charge may be required:

CRNA, Cytotechnologist, Emergency Medical Technician, Nurse Practitioner, Nurse Midwife, Optometrist, Perfusionist, Physician’s Assistant, Psychologist, Surgeon’s Assistant and Anesthesia Assistant.

- A. List all such allied health care professionals who provide services in your office as employees:

Name	DOB	SSN	Specialty	Check Desired Limits
				<input type="checkbox"/> Separate <input type="checkbox"/> Shared*
				<input type="checkbox"/> Separate <input type="checkbox"/> Shared*
				<input type="checkbox"/> Separate <input type="checkbox"/> Shared*
				<input type="checkbox"/> Separate <input type="checkbox"/> Shared*
				<input type="checkbox"/> Separate <input type="checkbox"/> Shared*
				<input type="checkbox"/> Separate <input type="checkbox"/> Shared*
				<input type="checkbox"/> Separate <input type="checkbox"/> Shared*

* Shared limits are not permitted in Pennsylvania and on a very limited basis in Wisconsin.

- B. Do you or any member of your group currently supervise, an “allied health care professional” as defined above, who is not in your employ?..... Yes No
- Do you plan to do so in the future? Yes No

C. Indicate the number of the following types of other individuals who provide services in your office as employees:

Number	Position	Number	Position
	Medical Assistant		Nurse (Registered or Licensed Vocational)
	Psychotherapist		Technician (Lab, Pathological, Dialysis, etc.)
	X-Ray Technician		Other

13. Additional Data

- A. Do any of your employees (not including physician(s)) practice at a location geographically separate from yours? Yes No
 If yes, please explain on pages 17-18.
- B. Do you, or does any partnership or corporation of which you are a member or shareholder, own or operate a surgicenter, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice? Yes No
 If yes, please explain on pages 17-18.
- C. Do you perform medical or surgical procedures at a surgicenter, office-based surgical suite or similar facility? Yes No
 If yes, on pages 17-18, provide the names of the facilities, describe the types of procedures, and provide approximate distance to the nearest hospital. Include type of anesthesia used (local, conscious sedation or general anesthesia), crisis protocol and description of on-site code management equipment (crash cart, etc.).

IMPORTANT! YOU MUST READ CAREFULLY

GENERAL FRAUD WARNING: 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.

Colorado Fraud Warning: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Florida Fraud Notice: 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.

Kentucky Fraud Warning: 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.

New Jersey Fraud Warning: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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.

Ohio Fraud Warning: 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.

Oklahoma Fraud Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania 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 subjects such person to criminal and civil penalties.

Virginia Fraud Warning: 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.

Wisconsin Exception: If the company agrees to be bound under the terms of this application, your policy will be cancelled if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application.

**Specific Consent
to Conditions of Consideration of the Application for Insurance**

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application – regardless of whether or not I am granted insurance – and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed medical doctor who makes application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

Applicant's Signature

Date

Important: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following page of this Application is an *Authorization To Release Information* form which requires your signature. Please read carefully.

Authorization to Release Information

The undersigned applicant for insurance by ProNational Insurance Company (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for any state in which he has practiced, or resided, and any and all physicians or any other third party having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

Date: _____

Physicians' & Surgeons' Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

- 1. Patient's name: _____
- 2. Date reported to insurance company: _____
- 3. Name of insurance company: _____
- 4. Date of incident and your treatment: _____
- 5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

8. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed but dropped by claimant
- Summary judgment in your favor
- Suit settled out of court
 - a. Date claim paid: _____
 - b. Amount paid: \$ _____
 - c. Did you want to settle this claim? Yes No

Court outcome in your favor:
 Jury verdict
 Directed verdict

Court outcome in favor of plaintiff:
 Jury verdict
 Directed verdict

Amt. of Loss Payment:
\$ _____

Awaiting mediation

Awaiting court action

Reserve Amount:
\$ _____

9. Name and address of the attorney assigned to your case: _____

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes No
If yes, amount paid: \$ _____

Signature: _____ Date: _____

Name (Printed): _____