



FREEDOM SPECIALTY
INSURANCE COMPANY®

Home Office:

One Nationwide Plaza • Columbus, Ohio 43215

Administrative Office:

8877 North Gainey Center Drive • Scottsdale, Arizona 85258

1-800-423-7675



MGIS UNDERWRITING MANAGERS, INC.

1849 West North Temple

Salt Lake City, Utah 84116-3067

1-800-969-6447 toll free

1-801-990-2400 phone

1-801-990-2401 fax

www.mgis.com

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY—INDIVIDUAL APPLICATION

NOTE: The insurance for which you are applying is a claims-made form of coverage. Only claims resulting from professional services rendered on or after the retroactive date of this insurance and reported during the policy period will be covered.

The policy provides additional benefits/coverage for:

- Defense Costs
- Attendance at Trial (at Company request)
- Appeal Bond Coverage
- Regulatory and Billing-Related Proceedings Defense Costs Reimbursement including Civil Monetary Penalties assessed in billing-related proceedings

See the policy for coverage and specific details.

Please follow these instructions when completing and submitting this application.

- A. Please type or legibly print your responses in full. If additional space is needed, please complete Section J. of this application or provide attachments. Application must be signed and dated within sixty (60) days of the desired effective date and received prior to desired effective date.
- B. Complete one "Individual" application for each physician. Answer all questions. Indicate "N/A" if a question is not applicable.
- C. Read and initial the State Statutory Requirement in Section K. of this application. Applications cannot be processed without completion of this statutory requirement.
- D. For coverage to exist, you must make separate application for any ancillary activity conducted by any separate entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture. If the entity is a corporation of any type, please attach a copy of Articles of Incorporation. Additional documentation pertaining to the entity's existence and operations may be requested as deemed necessary by the underwriter.

The following **MUST** be included with this application:

- **Copy of your current professional liability Insurance Declarations Page and any endorsements, and currently valued loss runs for the past ten (10) years.**
- **Copy of your medical license, Curriculum Vitae, and copy of board certification.**
- **Copy of your letterhead or sample billing statement.**
- **Claim/Suit Information Form with additional documentation as needed.**
- **Copies of all advertising that is used by you, including Yellow Page or Internet ads, relevant Web site, social media, etc.**

Return completed application to:

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BROKER INFORMATION

Firm Name: Physicians Insurance Consultants, Inc Firm Broker No.: _____
Producer: _____ Phone: 215-233-4410 E-mail: PIC1540@aol.com

A. GENERAL INFORMATION

1. Applicant Information:

Last name: _____ First name: _____ Middle name: _____
Degree: _____ Social Security No.: _____
Date of Birth: _____ Place of Birth (City/State/Country): _____

2. Practice Office Locations: (List principal location first. Total percent of practice of all locations must equal one hundred percent [100%])

Location 1.

Office Hospital/Surgi-Centers: (Admitting Non-Admitting)
Percent of Practice/Admissions: _____% Practice/Facility/Hospital Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____ County: _____

Location 2.

Office Hospital/Surgi-Centers: (Admitting Non-Admitting)
Percent of Practice/Admissions: _____% Practice/Facility/Hospital Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____ County: _____

Location 3.

Office Hospital/Surgi-Centers: (Admitting Non-Admitting)
Percent of Practice/Admissions: _____% Practice/Facility/Hospital Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____ County: _____

3. Residence Address:

Street Address: _____
City: _____ State: _____ Zip: _____ County: _____

4. Billing and Correspondence Address:

Location No. (from 2. above): _____ Residence Other (please enter below)
Business Manager/Contact Person: _____
Street Address: _____
City: _____ State: _____ Zip: _____ County: _____

5. Preferred Method of Contact: E-mail Business Fax Business Phone Residence Phone

E-mail: _____ Business Fax No.: _____
Business Phone No.: _____ Residence Phone No.: _____

6. Do you have a Web site address? Yes No

If Yes, please provide address: _____

B. EDUCATIONAL BACKGROUND (If additional space is needed, please use supplemental form)

1. Medical School:

School Name: _____

Street Address: _____

City: _____ State: _____ Country: _____

Degree: _____ From: _____ To: _____

If foreign medical school graduate:

Are you certified by The Educational Commission for Foreign Medical Graduates (ECFMG)?..... Yes No

If Yes, list date certified: _____

If No, please explain: _____

2. Residency: (List all resident training locations—i.e., residency specialty training, anesthesia residency training, etc. If more than one specialty completed, please enter each specific specialty.)

Location 1.

Hospital/Facility Name: _____

City: _____ State: _____ Country: _____

Specialty Type: _____

Completed?..... Yes No From: _____ To: _____

Location 2.

Hospital/Facility Name: _____

City: _____ State: _____ Country: _____

Specialty Type: _____

Completed?..... Yes No From: _____ To: _____

3. Have You Participated In Any Additional Training (i.e., Fellowship, etc.)?

Location 1.

Hospital/Facility Name: _____

City: _____ State: _____ Country: _____

Specialty Type: _____

Completed?..... Yes No From: _____ To: _____

Location 2.

Hospital/Facility Name: _____

City: _____ State: _____ Country: _____

Specialty Type: _____

Completed?..... Yes No From: _____ To: _____

4. Explain any gaps greater than six months between your medical school, residency, other training, or first time in private practice: _____

5. If you are currently in a residency or fellowship program, what is your anticipated residency/fellowship ending date?..... _____

a. Will this policy be covering your residency or fellowship? Yes No

b. Will this policy be covering your moonlighting while you are in your residency or fellowship? Yes No

Note: Your policy may be issued for less than one year in order to have the policy expiration date equal to the end date of your residency.

6. Are you entering private practice for the first time? Yes No

7. Have you participated in any continuing medical education within the last three years? Yes No
 If Yes, how many Category 1 credit hours? _____

8. Have you completed a risk management education course within the last twelve (12) months? Yes No

9. Are you a member of a medical school faculty? Yes No
 If Yes, what percentage of your time is spent treating patients whose treatment is unrelated to your physician duties at the medical school? %

C. PRACTICE INFORMATION (If additional space is needed, please use supplemental form)

1. Do you perform consultations, read x-rays or interpret test results for other physicians or organizations who render medical professional services in another state? Yes No

If this is covered by another professional liability insurance policy, complete Section D, Question 9)

If Yes, which state(s)? _____

2. a. List states in which you hold a license to practice medicine:

Please check the appropriate box to indicate the status of your license:

| STATE | LICENSE NO. | ACTIVE | INACTIVE | TEMPORARY | PENDING |
|-------|-------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

b. Narcotics/DEA No.: _____

3. Previous locations of practice: (List most recent first, dating back to completion date of formal training)

If no previous location(s), indicate your earliest start date at your current location(s): _____

Location 1.

Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty Type: _____ From: _____ To: _____

Location 2.

Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty Type: _____ From: _____ To: _____

Location 3.

Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty Type: _____ From: _____ To: _____

4. Explain any gaps greater than one month between practice locations: _____

5. To which medical societies/organizations do you belong (such as AMA, state, board specialty, MGMA, etc.)?

If none, please explain: _____

D. RATING INFORMATION (If additional space is needed, please use supplemental form)

NOTE: All percentages requested below for specialties, procedures and surgical activities are of your total practice. Please enter complete name of specialty/sub-specialty. Combined percentages must equal one hundred percent (100%).

| | | | |
|-----------------------|--|---------------------------|---|
| Present specialty | | Percent of Total Practice | % |
| Present sub-specialty | | Percent of Total Practice | % |

2. Are you permanently retired from the practice of clinical medicine? Yes No

3. Are you American Board Certified?..... Yes No

If Yes, list Specialty Board: _____ Date Certified: _____

If No, are you Board Eligible?..... Yes No

If Yes, when do you plan on taking your boards? _____

If No, have you ever taken a specialty board examination and failed to pass?..... Yes No

If Yes, how many times? _____

If Yes, please explain: _____

4. Indicate the average weekly numbers in each of the following categories for which you require coverage. If you practice in multiple states, please identify the following information for each state (Please provide whole numbers. If "NONE" enter "0" in the space provided below.)

| Patients Seen Per Week | Hours Per Week | Walk-In Patients Per Week |
|------------------------|----------------|---------------------------|
| | | |

5. Please check any of the following procedures you will perform:

| | | |
|---|---|---|
| <input type="checkbox"/> Abdominoplasty (Tummy Tuck) | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Pacemakers—Epicardial |
| <input type="checkbox"/> Abortions Therapeutic No./yr: _____ Elective No./yr: _____ | <input type="checkbox"/> Correct Anesthesia/ General/Spinal/Epidural | <input type="checkbox"/> Pacemakers—Endocardial |
| <input type="checkbox"/> Acupuncture—General Anesthetic | <input type="checkbox"/> Correct Bariatric— Non-Laparoscopic | <input type="checkbox"/> Pacemakers—Temporary |
| <input type="checkbox"/> Acupuncture—Therapeutic/Local Anesthetic | <input type="checkbox"/> Cryosurgery (Cervical) | <input type="checkbox"/> Peritoneoscopy |
| <input type="checkbox"/> Anesthesia General/Spinal/Caudal | <input type="checkbox"/> Cryosurgery (non-external lesions) | <input type="checkbox"/> Obstetrics |
| <input type="checkbox"/> Anesthesia—Other: | <input type="checkbox"/> D&C | <input type="checkbox"/> Phlebography |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Electromagnetic Therapy | <input type="checkbox"/> Pneumoencephalography |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Embolization | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> ERCP—Upper GI Endoscopy | <input type="checkbox"/> Prenatal/Gynecological Practice |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Face Lifts | <input type="checkbox"/> Prenatal—1 st & 2 nd Trimester |
| <input type="checkbox"/> Assisting in major surgery— own patients only | <input type="checkbox"/> Face Lifts Mini (done with laser) _____ % of total practice | <input type="checkbox"/> Prenatal—to term, no delivery |
| <input type="checkbox"/> Assisting in major surgery—own & other than own patients | <input type="checkbox"/> Gastrointestinal Endoscopy | <input type="checkbox"/> Prenatal—to term, delivery |
| <input type="checkbox"/> Bariatric Surgery—Laparoscopic | <input type="checkbox"/> Gynecology—Major Surgery | <input type="checkbox"/> Vaginal Deliveries— _____ total per year |
| | <input type="checkbox"/> Hair Transplants—Follicular Unit Transplantations | <input type="checkbox"/> Caesarean Deliveries— _____ total per year |
| | | <input type="checkbox"/> Vaginal after Caesarean Deliveries— _____ total per year |

| | | |
|--|---|--|
| <input type="checkbox"/> Bariatric Surgery— Non-Laparoscopic | <input type="checkbox"/> Hair Transplants—Other | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> HVLA on the cervical spine on patients younger than eighteen (18) years of age | <input type="checkbox"/> Radial/Laser Keratotomy |
| <input type="checkbox"/> Biopsy—Endoscopic | | <input type="checkbox"/> Radiation—Diagnostic |
| <input type="checkbox"/> Blepharopigmentation— _____ % of total practice | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Radiation—Interventional |
| <input type="checkbox"/> Blepharoplasty—Cosmetic _____ % of total practice | <input type="checkbox"/> Laparoscopic Cholecystectomy | <input type="checkbox"/> Radiation—X-Ray Therapy |
| | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Radiopaque Dye—Non-Ionic Only |
| <input type="checkbox"/> Blepharoplasty—Reconstruction— _____ % of total practice | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Radiopaque Dye—Other than Non-Ionic |
| <input type="checkbox"/> Botanical Medicine | <input type="checkbox"/> Laser Therapy (Endoscopic) | <input type="checkbox"/> Rectal Ozone Therapy |
| | <input type="checkbox"/> Laser Therapy (Non-Endoscopic) | <input type="checkbox"/> Rhinoplasty _____ % of total practice |
| <input type="checkbox"/> Botox _____ % of total practice | <input type="checkbox"/> Lipoinjection _____ % of total practice | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Brachioplasty | <input type="checkbox"/> Liposuction—Other than Tumescent Technique | <input type="checkbox"/> Shock Therapy |
| <input type="checkbox"/> Breast Implants—Cosmetic _____ % of total practice | | <input type="checkbox"/> Liposuction— Tumescent Technique Only _____ % of total practice |
| <input type="checkbox"/> Breast Implants—Reconstruction _____ % of total practice | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Sigmoidoscopy—Greater than 60cm |
| <input type="checkbox"/> Breast Reduction—Cosmetic | <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Silicone Injections _____ % of total practice |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Mammograms | <input type="checkbox"/> Skin Flaps/Grafts <input type="checkbox"/> Cosmetic _____ % of total practice <input type="checkbox"/> Reconstruction _____ % of total practice |
| <input type="checkbox"/> Bronco—Esophagology | <input type="checkbox"/> Manipulation Therapy | |
| <input type="checkbox"/> Buttock Implants | <input type="checkbox"/> Myelography | <input type="checkbox"/> Thigh Lift |
| <input type="checkbox"/> Calf Implants | <input type="checkbox"/> Nerve Blocks <input type="checkbox"/> Facet <input type="checkbox"/> Intrathecal Pumps <input type="checkbox"/> Lumbar Epidural Steroid <input type="checkbox"/> Myofascial <input type="checkbox"/> Occipital <input type="checkbox"/> Paraspinal <input type="checkbox"/> Paravertebral <input type="checkbox"/> Peripheral <input type="checkbox"/> Sciatic <input type="checkbox"/> Spinal Cord Stimulators <input type="checkbox"/> Triggerpoint Injection | <input type="checkbox"/> Tubal Ligations |
| <input type="checkbox"/> Cataract Surgery | | <input type="checkbox"/> Vasectomies—Own Patients Only |
| <input type="checkbox"/> Catheterization—Left Heart | | <input type="checkbox"/> Vasectomies—Own & Other than Own Patients |
| <input type="checkbox"/> Catheterization—Right Heart (other than CVP lines) | | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Cheek/Chin/Lip Implants | | <input type="checkbox"/> Weight Control Medication _____ % of total practice |
| <input type="checkbox"/> Chelation Therapy | | <input type="checkbox"/> Other Medical Techniques _____ |
| <input type="checkbox"/> Chemical Peels—Superficial | | <input type="checkbox"/> Other Medical Techniques _____ |
| <input type="checkbox"/> Chemical Peels—Medium | | <input type="checkbox"/> Other Medical Techniques _____ |
| <input type="checkbox"/> Chemical Peels—Deep _____ % of total practice | | <input type="checkbox"/> Other Medical Techniques _____ |
| <input type="checkbox"/> Cleft Lip Surgery—Reconstructive | | <input type="checkbox"/> Needle Biopsy |
| <input type="checkbox"/> Cleft palate Surgery— Reconstructive | <input type="checkbox"/> Oxidation Therapy | <input type="checkbox"/> Other Medical Techniques _____ |

6. Indicate the percentage of your total practice devoted to the following surgical activities:

| | | | |
|-----------------------|---------------------------|---|-------------------|
| Abdominal % | Hand % | Orthopedic (including Back) % | Urology..... % |
| Bariatric..... % | Head and Neck % | Orthopedic (not including Back) % | Vascular % |
| Cardiac..... % | Neoplastic Surgery..... % | Otorhinolaryngology... % | Other (Describe): |
| Colon/Rectal..... % | Nephrology..... % | Plastic (Cosmetic Enhancement) % | _____ |
| Endocrinology % | Neurosurgery % | Plastic (Reconstruction Only) % | _____ |
| General % | Obstetrics..... % | Thoracic..... % | _____ |
| Gynecology % | Ophthalmology..... % | Traumatic..... % | _____ |

7. In the last ten (10) years:

a. Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity? Yes No
 If Yes, list procedures/activities, date discontinued and reason for discontinuing: _____

b. Have you performed weight control surgery or prescribed weight control medication?..... Yes No
 If Yes, what percentage of your practice (percentage of patient care) was devoted to prescribing anorectic drugs?
 <1% 1%-10% 11%-50% >50% Never prescribed weight control medication
 If Yes, what percentage of your practice (percentage of patient care) was devoted to performing weight control surgery?
 <1% 1%-10% 11%-50% >50% Never performed weight control surgery

c. Do you have ownership interests in a weight control clinic? Yes No
 If Yes, what is the name of the weight control clinic with which you are affiliated? _____

8. Do you serve in a hospital emergency room for which you require coverage?..... Yes No

a. If Yes, list number of hours per month (excluding "on-call" hours): _____
 b. If Yes, are the hours you work in the ER the minimum number of hours required to maintain hospital privileges?..... Yes No
 c. For what institution? _____

If coverage is to be provided by another carrier, please provide evidence of other coverage.

9. Will you be performing activities which will be covered by another professional liability policy? Yes No

If Yes, complete the following: Employee Independent Contractor Resident/Fellow Faculty
 Practice Name and Locations: _____
 Name of Carrier: _____

10. Please use the space below for any comments you feel will help the insurer to better understand any special circumstances concerning your practice: _____

E. ADDITIONAL PROFESSIONAL INFORMATION

Please fully explain any "Yes" answer, in *Section J., Applicant Additional Comments.*

1. Do you perform surgery on or are you a team physician for any professional or collegiate athletes? Yes No
If Yes, what percentage of your practice is devoted to this activity? %
(If you are covered by other insurance for this activity, please complete Section D., Question 9.)
2. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No
If Yes, include a copy of the indemnification agreement provided by the pharmaceutical company.
(If you are covered by other insurance for this activity, please complete Section D., Question 9.)
3. Do you practice in a nursing home facility? Yes No
If Yes, what percentage of your practice is devoted to this activity? %
(If you are covered by other insurance for this activity, please complete Section D., Question 9.)
4. Do you treat or review treatment of federal prison inmates? Yes No
(If you are covered by other insurance for this activity, please complete Section D., Question 9.)
5. Do you treat non-federal prison inmates? Yes No
If Yes, what percentage of your practice is devoted to this activity? %
Does this facility have a Law Library? Yes No
(If you are covered by other insurance for this activity, please complete Section D., Question 9.)
6. Are you an employee of, or do you do contract work for, any government agency? Yes No
If Yes, provide name: _____
7. Do you use a collection agency which has the authority to file collection suits without your knowledge? Yes No
8. Do you practice as a medical director? Yes No
If Yes, what percentage of your practice is devoted to this activity? %
Type and Name of Facility: _____
(If you are covered by other insurance for this activity, please complete Section D., Question 9.)
9. Do you admit patients for other physicians? Yes No
10. Do you practice as a hospitalist? Yes No
 - a. Individual (Solo Practice)? Yes No
Please provide name and Federal ID of the solo professional corporation or service corporation: _____
 - b. Employee? Yes No
Name of employer: _____
 - c. Independent Contractor? Yes No
Name of hiring party to contract: _____
 - d. Partner/Shareholder? Yes No
Name of corporation/partnership: _____
Federal ID of the solo professional corporation or service corporation: _____
11. Do you engage in any "moonlighting" activity, apart from your practice? Yes No
12. Do you work with a blood bank? Yes No

13. If you are NOT a radiologist:

- a. Do you take and/or interpret your own X-rays or other imaging procedures? Yes No
If Yes, estimated number per year: _____
- b. Does a radiologist over-read your X-rays? Yes No
- c. If a non-radiologist is over-reading your X-rays, indicate who and what specialty: _____

14. Do you perform surgery in your office? Yes No

If Yes, list the specific procedures you perform: _____
Is general anesthesia administered for these office procedures? Yes No
If Yes, by whom and with what training? _____

15. Do you perform invasive pain management procedures? Yes No

If Yes, list the procedures you perform and indicate if each is done in a hospital or office: _____

16. Do you devise or review plan/employer safety standards? Yes No

If Yes, what products are manufactured by the company? _____
Company Name and Location: _____

(If you are covered by other insurance for this activity, please complete Section D., Question 9.)

17. If you answer "Yes" to any of the following, please indicate date(s) and explain:

- a. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society? Yes No
- b. Has any state ever refused your license to practice medicine? Yes No
- c. Has any state ever restricted, suspended or revoked your license to practice medicine? Yes No
- d. Has any state agency ever placed you on probation or restricted your practice? Yes No
- e. Have you ever been investigated by any governmental agency? Yes No
- f. Has any hospital ever denied, restricted, reduced or suspended your privileges or invoked probation? Yes No
- g. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? Yes No
- h. Are you now being, or have you ever been, treated for or suffered from alcoholism, chemical dependency or mental illness? Yes No
- i. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine? Yes No
- j. Have you ever been investigated for or had any sexual misconduct or battery allegations filed against you? Yes No
- k. Have you ever been convicted or are you currently under investigation for a crime other than a traffic offense? Yes No
- l. Have you ever been refused board certification? Yes No
- m. Have you ever had professional liability insurance declined, canceled, rescinded, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or had renewal refused? .. Yes No
To your knowledge is any such action under consideration by any current medical professional liability insurer? Yes No

F. PRACTICE ORGANIZATION INFORMATION (If additional space is needed, please use supplemental form)

1. Indicate the number of each of the following who provide services in your office (include yourself):

| | | | |
|--------------------------|--|-------------------------------|--|
| Dentists | | Perfusionists | |
| Case Managers | | Physicians | |
| Chiropractors | | Physician Assistants | |
| CRNAs/RNAs | | Physician Surgical Assistants | |
| Nurse Midwife Assistants | | Podiatrists | |
| Nurse Midwives | | Psychologists | |
| Nurse Practitioners | | Respiratory Therapists | |
| Occupational Therapists | | Surgical Assistants | |

2. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services? Yes No

If No, do you plan to do so in the future?..... Yes No

If Yes, please provide an explanation: _____

3. Practice organization:

Check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under employment status. You MUST check at least ONE box.

SOLO UNINCORPORATED/SOLE PROPRIETOR

Entity Name: _____

Date Joined/formed: _____

Employment Status: Employee Shareholder/Partner Independent Contractor Other

If other, please explain: _____

SOLO INCORPORATED

Entity Name: _____

Date Joined/formed: _____

Employment Status: Employee Shareholder/Partner Independent Contractor Other

If other, please explain: _____

Is this entity or employer currently insured with us?..... Yes No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? Yes No

If Yes, do you have any employed or contracted physicians associated with your practice?..... Yes No

If No, do you wish to share your individual policy limits with your solo corporation?..... Yes No

If Yes, and you desire to share your individual policy limits, please initial here: (initials)

Note: To qualify for shared limit solo corporation coverage, you must have no physician employees or physician independent contractors.

If you desire separate policy limits or you do not qualify for "solo corporation" coverage, please contact your agent to complete a separate Corporate Application for consideration.

MULTI-SHAREHOLDER CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY

Entity Name: _____

Date Joined/Formed: _____

Employment Status: Employee Shareholder/Partner Independent Contractor Other

If other, please explain: _____

Is this entity or employer currently insured with us?..... Yes No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? Yes No

HOSPITAL **INDUSTRIAL** **GOVERNMENT-BRANCH**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: Employee Shareholder/Partner Independent Contractor Other

If other, please explain: _____

Is this entity or employer currently insured with us?..... Yes No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? Yes No

STATE LICENSED MEDICAL SURGERY CENTER:

FOR USE BY OTHER PHYSICIANS **YOUR PATIENTS ONLY**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: Employee Shareholder/Partner Independent Contractor Other

If other, please explain: _____

Is this entity or employer currently insured with us?..... Yes No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? Yes No

OTHER (PLEASE EXPLAIN)

Entity Name: _____

Date Joined/Formed: _____

Employment Status: Employee Shareholder/Partner Independent Contractor Other

If other, please explain: _____

Is this entity or employer currently insured with us?..... Yes No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? Yes No

4. If the business purpose of the entity noted above is other than a medical office practice, please explain: _____

G. LOSS INFORMATION (If additional space is needed, please use supplemental form)

Complete and attach a Claims/Suit Information Form for EACH claim, potential claim, or suit.

New Business Applicant: Please attach a current loss run from all previous carriers.

If you answer Yes to any of Questions 1.-4., and a description of the events is not included with the loss run, please provide copies of report(s) made to previous carriers or detail circumstances.

1. Have any professional liability claims or notices against you been arbitrated, mediated, litigated, dismissed, settled, or are currently pending? Yes No
 If Yes, how many? _____
 If Yes, have these been reported to your insurer? Yes No
2. Indicate below if you are 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).
 - a. A request for records from a patient/attorney related to an adverse outcome?..... Yes No
 - b. A letter from a patient/attorney regarding your medical treatment of a patient?..... Yes No
 - c. Intra-operative complications or other complications resulting in death, paralysis or any significant injuries including those related to the use of prescribed drugs?..... Yes No
3. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits, (even if you believe the claim or suit would be without merit), that have not been reported to your current or prior professional liability carrier?..... Yes No
4. Have you ever been accused of professional negligence, or has a suit or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged based upon your acts or omissions? Yes No
5. Have you ever had any insurance company decline, cancel, rescind or non-renew any professional and/or general liability insurance policy (Not applicable in Missouri)? Yes No
 If Yes, provide details: _____
6. Have you ever had any proceedings/investigations/audits regarding billing practices or billing errors, HIPAA, EMTALA, or STARK proceedings instituted against you?..... Yes No
 If Yes, did they result in legal or audit expenses, fines or penalties?..... Yes No

H. COVERAGE INFORMATION (If additional space is needed, please use supplemental form)

1. List all previous professional liability insurers dating back to completion of formal training beginning with the most recent:

| Name of Insurer | Coverage Type C=Claims-Made O=Occurrence | Limits | Deductible (if any) | Policy Period | |
|-----------------|--|--------|------------------------|---------------|----|
| | | | | From | To |
| | | \$ | \$ | | |
| | | \$ | \$ | | |
| | | \$ | \$ | | |
| | | \$ | \$ | | |

Please explain any gaps in coverage back to your start date of practice: _____

2. Coverage desired

- a. Claims-Made Coverage without Prior Acts Coverage
- b. Claims-Made Coverage with Prior Acts Coverage (A copy of current declaration page showing current retroactive date must be attached)

If A. is selected above and the most recent prior coverage was issued on a Claims-Made basis, select one of the following:

- An extended reporting endorsement (tail coverage) has been purchased (copy of tail is attached)
- An extended reporting endorsement has not and will not be purchased (please explain)

I will not purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying for will not provide prior acts of coverage.

Initial Here: _____

Claims-made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to claims-made coverage or the additional expense associated with an Extended Reporting Endorsement or "tail coverage."

3. Requested coverage effective date 12:01 a.m.

FROM: _____ 12:01 a.m. TO: _____ 12:01 a.m.

(This date cannot be earlier than the expiration date of your current policy)

Note: Annual Policy terms will begin and end on the same month and day. If you are joining an existing insured/group, your coverage may be issued to a common expiration date.

4. Retroactive date shown on my current claims-made policy is: _____ 12:01 a.m.

5. If you practice in the fund states of Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, or Wisconsin, please indicate your current fund retroactive date if different than the retroactive date stated above: _____ 12:01 a.m.

Are you aware of any gaps in your fund coverage? Yes No
 If Yes, provide exact dates and an explanation: _____

6. If you practice in more than one state, indicate the state and the limits desired for each state.

Add additional states if needed.

| State | Limits Desired | Per claim | Annual Aggregate |
|-------|----------------|-----------|------------------|
| | \$ | \$ | \$ |
| | \$ | \$ | \$ |
| | \$ | \$ | \$ |

Note: Requested limits may not be available from this company. You may be eligible for fund coverage in accordance with state fund guidelines. Limits may be adjusted accordingly.

I. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

By initialing below, I assign to the following employer or named third party (include name and address) both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to Freedom Specialty Insurance Company, Administrative Offices at 8877 North Gainey Center Drive, Scottsdale, Arizona 85258.

Name: _____
 Address: _____

Initial Here: _____

NOTE: Your right to cancel and receive any premium refund will automatically be assigned.

1. To the First Named Insured if you are covered under a group policy.
2. To a third-party finance company if it pays your premium on your behalf.

J. APPLICANT ADDITIONAL COMMENTS

Use this space to provide any additional details, explanations or information that you believe may be pertinent to this application. You are also encouraged to attach any pages containing supplemental information that you believe may be helpful.

| Question No. | Explanation |
|--------------|-------------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

K. STATE STATUTORY REQUIREMENT

Notice to Arizona Applicants: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas and Rhode Island 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 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 policy holder 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 in the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana 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 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 Maryland Applicants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 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 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 Oklahoma Applicants: 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.

Notice to Pennsylvania 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 subjects such person to criminal and civil penalties.

Notice to Tennessee and Washington 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.

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.

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 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.

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, including all attachments shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional entity, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS, *I WILL HAVE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.*

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding my organization, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

By signing this application on behalf of an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity) I warrant that I am an Officer, Partner, Office Administrator or AUTHORIZED REPRESENTATIVE of the entity applying for coverage.

Application must be signed by a President, Chief Executive Officer, or other Officer or Partner of a PC or PA or the Office Administrator or AUTHORIZED REPRESENTATIVE.

SIGNATURE DATE SIGNED

PRINT NAME AND TITLE E-MAIL ADDRESS

The following **MUST** be included with this application:

- Copy of your current professional liability Insurance Declarations Page and any endorsements, and currently valued loss runs for the past ten (10) years.
- Copy of your medical license, Curriculum Vitae, and copy of board certification.
- Copy of your letterhead or sample billing statement.
- Claim/Suit Information Form with additional documentation as needed.
- Copies of all advertising that is used by you, including Yellow Page or Internet ads, relevant Web site, social media, etc.

Attach to your application

K. CLAIMS/SUIT INFORMATION FORM (Complete one form for each claim, potential claim or suit)

If making additional copies, please enter applicant's name here: _____

NOTE: Additional documentation (office/hospital records) may be requested at the underwriting department's discretion.

1. Claimant information (indicate if different from patient):

Name (First, MI, Last) _____ Age: ____ Male Female

2. Date of treatment and/or surgery, which led to the allegations against you: _____

3. Date claim/incident notice received: _____

4. Date claim reported to prior insurer: _____

5. List name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: _____

6. Disposition or current status of claim or suit:..... Open Closed

If closed, indicate date of closing/settlement or award: _____

7. Indicate case value established by carrier, if known: \$ _____

8. Defending insurance carrier name: _____

9. Claim file number: _____

10. Additional claim information:

a. Was a suit filed?..... Yes No

b. Was payment made? Yes No

c. If no, was claim or suit withdrawn?..... Yes No

d. If yes, was verdict or judgment in favor of entity or plaintiff? Entity Plaintiff

e. If yes, indicate total amount of settlement or award: \$ _____

f. Amount paid on your behalf: \$ _____

11. Nature of allegations in the claim or suit:

a. Condition treated: _____

b. Treatment provided: _____

c. Alleged negligence: _____

d. Alleged injury: _____

12. Provide a narrative description of the medical facts (must include, but is not limited to, the type of treatment and/or surgery and your involvement): _____

SIGNATURE

DATE SIGNED

PRINT NAME AND TITLE

E-MAIL ADDRESS