



Ten Parkway North, Deerfield, IL 60015
 (847) 572-6000 Fax (847) 572-6137
 Underwriting Manager

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

If you obtained this application at www.markelshand.com, please submit this application through your local insurance professional.

APPLICATION FOR PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: _____
 (ii) Professional Degree: _____
- (b) Principal practice address: _____
 _____ (Street) _____ (County)
 _____ (City) _____ (State) _____ (Zip)
- (c) Secondary practice locations: _____

- (d) (i) Phone: _____ (ii) Fax: _____
 (iii) E-Mail Address: _____ (iv) Website Address: _____
- (e) (i) Date of Birth (MM/DD/YYYY): _____ (ii) Place of Birth: _____
- (f) (i) Social Security No.: _____ (ii) Federal Tax ID Number: _____
2. Are you a U.S. citizen? [] Yes [] No
 If No, what is your status in the U.S. and current citizenship? _____
3. (a) Type of practice: [] solo practitioner (unincorporated) [] solo practitioner (incorporated)*
 [] professional corporation* [] professional association*
 [] limited liability company* [] partnership*
 [] employee of _____ [] independent contractor of _____
 [] other _____
 * Specify name of entity: _____
- (b) Do you want coverage for the entity named Item 3(a) above? [] Yes [] No
- (c) Attach a copy of your letterhead.
- (d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all physicians practicing under the entity name in Item 3(a) above.

4. Do you practice with any physician not named in Item 3.(d) above? [] Yes [] No
 If Yes, provide the name of each physician and the practice relationship. _____

5. Are you currently in active military service? [] Yes [] No

6. Provide the following information for all of the states in which you practice:

| <u>State</u> | <u>License No.</u> | <u>Effective Date</u> | <u>Expiration Date</u> | <u>Active (Yes/No)</u> |
|--------------|--------------------|-----------------------|------------------------|------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

7. Federal DEA License No. and status: _____

8. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

| <u>Name</u> | <u>City</u> | <u>State</u> | <u>Percentage of Work</u> | <u>Type of Privileges</u> |
|-------------|-------------|--------------|---------------------------|---------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

9. Are you currently a hospital chief of staff or head of any hospital department? [] Yes [] No
If Yes, describe. _____

10. Do you or the entity firm named in Item 3(a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgicenter, urgent care center other facility where medical services are customarily provided? [] Yes [] No
If Yes, provide a detailed explanation specifically including the name, location, size, and number of beds. _____

11. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [] Yes [] No
If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... [] Yes [] No
(ii) Provide the name and title of the Applicant's Privacy Officer. _____

Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

II. EDUCATION AND TRAINING

1. (a) Provide your medical or surgical specialty: _____
(b) Do you limit your practice to the specialty stated in item (a) above?..... [] Yes [] No
(c) Do you have a subspecialty?..... [] Yes [] No
If Yes, describe. _____

2. Are you American Board certified? [] Yes [] No
If Yes, provide the following: Medical specialty in which you are certified: _____
Date of certification: _____ Any recertification date(s): _____
If No, do you plan on taking the Board examination? [] Yes [] No

3. Provide the following information:

| | <u>Name of Institution</u> | <u>City</u> | <u>State</u> | <u>Date Completed</u> |
|-------------------------------|----------------------------|-------------|--------------|-----------------------|
| Medical School | _____ | _____ | _____ | _____ |
| PGY-1/Internship | _____ | _____ | _____ | _____ |
| Residency – Specialty: _____ | _____ | _____ | _____ | _____ |
| Residency – Specialty: _____ | _____ | _____ | _____ | _____ |
| Fellowship – Specialty: _____ | _____ | _____ | _____ | _____ |
| Other: _____ | _____ | _____ | _____ | _____ |

4. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? [] Yes [] No
If Yes, provide the following: year of certification: _____ describe your medical degree: _____

5. Provide a detailed summary of where you have practiced your profession since completing your training:

6. Are you a member of any professional societies? [] Yes [] No
 If Yes, provide information regarding your membership(s). _____

7. How many hours of continuing medical education have you take within each of the last two (2) years? _____

III. SCOPE OF PRACTICE

1. (a) Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia? [] Yes [] No
 If Yes, complete 1.(b) below.

(b) If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: **H** = Hospital **O** = Office **S** = Surgi-center of other

| | <u>Location</u> | | <u>Location</u> |
|--|-----------------|---|-----------------|
| <input type="checkbox"/> Abortions - 1st Trimester | _____ | <input type="checkbox"/> Hysterectomies | _____ |
| <input type="checkbox"/> Abortions - 2nd/3rd Trimester | _____ | <input type="checkbox"/> Laser skin resurfacing | _____ |
| <input type="checkbox"/> Acupuncture | _____ | <input type="checkbox"/> Laser Surgery (describe) _____ | _____ |
| <input type="checkbox"/> Adenoidectomy/Tonsillectomy | _____ | <input type="checkbox"/> Lymphangiography | _____ |
| Anesthesia – Non-obstetrical: | | <input type="checkbox"/> Minimally invasive surgery (describe) _____ | _____ |
| <input type="checkbox"/> General | _____ | <input type="checkbox"/> Moh's micrographic surgery | _____ |
| <input type="checkbox"/> Spinal | _____ | <input type="checkbox"/> Myelography | _____ |
| <input type="checkbox"/> Epidural | _____ | <input type="checkbox"/> Needle biopsies (describe) _____ | _____ |
| Anesthesia – Obstetrical: | | Obstetrics: | |
| <input type="checkbox"/> General | _____ | <input type="checkbox"/> Prenatal care | _____ |
| <input type="checkbox"/> Spinal | _____ | <input type="checkbox"/> Normal deliveries - annual no. _____ | _____ |
| <input type="checkbox"/> Epidural | _____ | <input type="checkbox"/> Caesarean sections - annual no. _____ | _____ |
| <input type="checkbox"/> Anesthesia – Other (describe) _____ | _____ | <input type="checkbox"/> VBAC deliveries – annual no. _____ | _____ |
| <input type="checkbox"/> Angiography | _____ | <input type="checkbox"/> Open Reduction of Fractures | _____ |
| <input type="checkbox"/> Angioplasty | _____ | <input type="checkbox"/> Pain Management (describe) _____ | _____ |
| <input type="checkbox"/> Anti-aging procedures – other than use of human growth hormone (describe) _____ | _____ | Plastic – Cosmetic Procedures: | |
| <input type="checkbox"/> Arteriography | _____ | <input type="checkbox"/> Blepharoplasty | _____ |
| <input type="checkbox"/> Assisting in Surgery – on own patients or the patients of others | _____ | <input type="checkbox"/> Collagen injections | _____ |
| <input type="checkbox"/> Breast Implants | _____ | <input type="checkbox"/> Botox injections | _____ |
| <input type="checkbox"/> Breast Reductions | _____ | <input type="checkbox"/> Liposuction under 3500 cc's volume | _____ |
| <input type="checkbox"/> Catheterization - other than umbilical cord, urethral or arterial line in a peripheral vessel | _____ | <input type="checkbox"/> Liposuction 3500 cc's or more volume | _____ |
| <input type="checkbox"/> Cosmetic implantation or injection of silicone or other material | _____ | <input type="checkbox"/> Phalloplasty or penile implant | _____ |
| <input type="checkbox"/> Cryosurgery - other than on benign or pre-malignant dermatological lesions | _____ | <input type="checkbox"/> Rhinoplasty | _____ |
| <input type="checkbox"/> Chelation Therapy | _____ | <input type="checkbox"/> Silicone implants | _____ |
| <input type="checkbox"/> Dermabrasion/Chemical Peels | _____ | <input type="checkbox"/> Silicone injections | _____ |
| <input type="checkbox"/> Dilation & Curettage | _____ | <input type="checkbox"/> Other plastic – cosmetic procedures (describe) _____ | _____ |
| <input type="checkbox"/> Discograms | _____ | <input type="checkbox"/> Pneumoencephalography | _____ |
| <input type="checkbox"/> Electroconvulsive Therapy | _____ | <input type="checkbox"/> Prolotherapy/proliferative therapy | _____ |
| <input type="checkbox"/> Endoscopic procedures | _____ | <input type="checkbox"/> Radiation Therapy | _____ |
| <input type="checkbox"/> Hair Transplants or Suturing of Hairpieces | _____ | <input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae | _____ |
| <input type="checkbox"/> Hyperbaric Medicine | _____ | <input type="checkbox"/> Refractive surgery: LASIK, PRK, AK, PTK, ICR | _____ |
| | | <input type="checkbox"/> Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy) | _____ |
| | | <input type="checkbox"/> Trans Myocardial Laser procedures | _____ |

2. (a) Do you perform surgery for obesity? [] Yes [] No
If Yes, complete 2.(b) below.
- (b) If you perform any of the following procedures, check all that apply and provide the number of procedures performed:
- Roux-en-Y:
- ___ Laparoscopic:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____
- ___ Open:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____
- Banding:
- ___ Laparoscopic:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____
- ___ Open:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____
- Gastric Restriction, Other (describe) _____:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____
3. Is general anesthesia administered for any of the procedures identified in 1.(b) or 2. above? [] Yes [] No
If Yes, is anesthesia administered by:
- (a) you? [] Yes [] No
- (b) an Anesthesiologist? [] Yes [] No
- (c) a Certified Registered Nurse Anesthetist (CRNA)? [] Yes [] No
If Yes, is the CRNA directed by or responsible to an Anesthesiologist? [] Yes [] No
If No, explain the type of surgery and percentage of your surgeries or average number of such cases per month.
-
- (d) Are Harvard Standards for the administration of all anesthesia adhered to? [] Yes [] No
4. (a) Do you perform any surgery in your office? [] Yes [] No
If Yes, answer the following:
- (i) Describe each procedure not already identified above in 1(b) or 2 above: _____

- (ii) Is your surgical suite certified? [] Yes [] No
If Yes, provide the name of the certification body. _____
- (b) Do you perform any surgery in other non-hospital facilities? [] Yes [] No
If Yes, answer the following:
- (i) Describe each procedure not already identified above in 1(b) or 2 above: _____

- (ii) Name each facility: _____

5. With the exception of surgery for obesity, does your practice include weight reduction or control by other than diet or exercise? [] Yes [] No
If Yes, answer the following:
- (a) Percentage of your patients that are weight control patients: _____
- (b) Do you dispense any drugs? [] Yes [] No
If Yes, provide the name(s) of the drug(s) dispensed. _____

- (c) Do you use injections for weight control? [] Yes [] No
If Yes, provide the name(s) of the drugs injected. _____
6. Do you perform any hospital emergency room care?..... [] Yes [] No
If Yes, is this solely a requirement for active admitting privileges? [] Yes [] No
If No, provide a detailed description including the approximate number of hours per month spent in emergency room care. _____
-
7. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? [] Yes [] No
If Yes, provide the following:
(a) Identify all states in which such patients reside: _____
(b) What percentage of your total practice is involved in such activities? _____
8. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? [] Yes [] No
If Yes, identify all states in which such patients reside. _____
9. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery?..... [] Yes [] No
If Yes, do you follow FDA-approved protocols? [] Yes [] No
If Yes, describe. _____
-
- (b) Are you a Principal Investigator for any clinical trial?..... [] Yes [] No
10. (a) Indicate the number of professional employees in your practice for each of the following: (If none, check here []) _____
 ___ Physicians other than yourself ___ Podiatrists ___ Chiropractors ___ Optometrists
 ___ Physician's Assistants* ___ Nurses ___ Nurse Practitioners* ___ Nurse Anesthetists*
 ___ Surgeon's Assistants* ___ Nurse Midwives* ___ Psychologists
 ___ Other (describe) _____
 *Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.
- (b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? [] Yes [] No
If No, provide a detailed explanation on a separate page.
11. (a) Average weekly patient load: _____ (b) Number of patients annually: _____
12. Average number of hours you practice each week: _____
13. What is your approximate gross annual income from your practice? (Check one.)
 ___ Less than \$50,000 ___ \$50,000 to \$99,999
 ___ \$100,000 to \$149,999 ___ \$150,000 to \$199,999
 ___ \$200,000 to \$499,999 ___ \$500,000 or more (estimate) \$ _____
14. Do you supervise anyone other than your own employees? [] Yes [] No
If Yes, indicate by profession the number of individuals you supervise:
 ___ Physicians other than yourself ___ Podiatrists ___ Chiropractors ___ Optometrists
 ___ Physician's Assistants ___ Nurses ___ Nurse Practitioners ___ Nurse Anesthetists
 ___ Surgeon's Assistants ___ Nurse Midwives ___ Psychologists
 ___ Radiology Technicians ___ Laboratory Technicians ___ Other (describe) _____
 Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. _____
-

15. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

| Ins Company | Limits of Liability | Premium | Eff./Exp. Dates | Claims Made or Occurrence Form | Retroactive Date |
|-------------|---------------------|---------|-----------------|--------------------------------|------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

16. Do you currently participate in any state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? [] Yes [] No

17. Do you anticipate any changes in your practice in the next year? [] Yes [] No
If Yes, attach a detailed explanation.

IV. AFFILIATIONS

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section I. 3(a) above? [] Yes [] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section I. 3(a) above? [] Yes [] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

If Yes, does any contract contain a hold harmless agreement? [] Yes [] No
If Yes, attach a copy of the contract.

3. Are you in the employ of or under contract to any governmental entity? [] Yes [] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

4. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? [] Yes [] No
If Yes, attach a copy of all advertisements.

5. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? [] Yes [] No
If Yes, attach a copy of the advertisement or applicable website address.

6. Are you the Medical Director of a nursing home, clinic, commercial enterprise or any other organization? [] Yes [] No
If Yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position. _____

7. Do you have any administrative or teaching responsibilities? [] Yes [] No
If Yes, provide the following and attach a copy of any contract or agreement:

(a) Name of entity and location: _____
Your title _____

(b) Does the entity provide you coverage for:
(i) Your administrative responsibilities? [] Yes [] No
(ii) Your direct patient care? [] Yes [] No

8. Do you work for any locum tenens companies? [] Yes [] No
 If Yes, provide the following :
- (a) Name of each company that places you in locum positions: _____
- (b) Are you an [] Employee or [] Independent Contractor?
- (c) Number of hours each month in which you work in locum positions: _____
- (d) Does each company provide you with Professional Liability Insurance for locum positions? [] Yes [] No
 If Yes, attach a copy of your Certificates of Insurance.
9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location? [] Yes [] No
 If Yes, provide details. _____
10. Are you engaged in or planning to engage in any "moonlighting" activities?..... [] Yes [] No
 If Yes, do you want coverage for your "moonlighting" activities?..... [] Yes [] No
 If Yes, describe the activities. _____

V. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? [] Yes [] No
 If Yes, how many? _____ Complete a Markel Shand, Inc. Supplemental Claim form for each one.
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? [] Yes [] No
 If Yes, how many? _____ Complete a Markel Shand, Inc. Supplemental Claim form for each one.
3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? .. [] Yes [] No
 If Yes, how many? _____ Complete a Markel Shand, Inc. Supplemental Claim form for each one.
4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? [] Yes [] No
5. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? [] Yes [] No
6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? [] Yes [] No
7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? [] Yes [] No
8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? [] Yes [] No
9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty?..... [] Yes [] No

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

Markel Shand, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.



MARKEL SHAND, INC.

Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY (Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Markel Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: