MEDICUS INSURANCE COMPANY

Agency ______________ Insured _____________

I. Coverage Requested

Effective Date: ______________________________	Limits of Liability: ❑ $200,000 per occurrence / $600,000 aggregate ❑ $500,000 per occurrence / $1,000,000 aggregate ❑ $1,000,000 per occurrence / $3,000,000 aggregate

II. Current Practice

Average weekly patient load: ______________________________	% of practice outside of office location: ______________________________

Do you practice medicine, in whole or in part, as an employee or consultant to a commercial enterprise, governmental body, military service, educational facility or professional sports organization?	❑ Yes	❑ No
For whom? ______________________________		

Do you function as a hospitalist?	❑ Yes	❑ No	If "Yes," provide the name of the hospital and the duties performed.
______________________________			

III. Medical Staff

Do you personally employ any of the following support personnel? Include number of employees by category.

❑	Med Lab Tech	#	❑	RN	#	❑	Physiotherapist	#
❑	Pharmacist	#	❑	Optometrist	#	❑	Psychologist	#
❑	Scrub Nurse	#	❑	Optician	#	❑	Surgical Assistant	#
❑	Med Assistant	#	❑	LVN / LPN	#	❑	Other:	#

Indicate the number employed by you or your group of the following non-physician health care providers.

❑	CNM	#	❑	Nurse Practitioner	#	❑	Other	#
❑	CRNA	#	❑	Physician Assistant	#	❑	Other	#
❑	OR Technician	#	❑	Radiology Technician	#	❑	Other	#

IV. Medical Procedures

Check the appropriate box, indicating the extent of surgery you perform.

❑	No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing of minor lacerations		
❑	Assisting in major surgery on your own patients.	# Annually	
❑	Assisting in major surgery on patients other than your own	# Annually	
❑	Minor surgery (Includes most procedures performed under local anesthesia)	# Annually	
❑	Normal obstetrical deliveries	# Annually	
❑	Major surgery (Includes all procedures done under general spinal or caudal anesthesia, and specifically includes tonsillectomy, appendectomy, D&C, cesarean section, abortion, and open reduction of fractures)	# Annually	

Check the following procedures which you perform. ❑ **NONE**

Primary	Assist		Primary	Assist		Primary	Assist	
❑	❑	Abortion # per year: ______________	❑	❑	Experimental surgery	❑	❑	Pain management (other than oral analgesics)
❑	❑	Acupuncture or Acupressure	❑	❑	Fertility/infertility treatment	❑	❑	Pre-natal care
❑	❑	Adnoidectomy	❑	❑	Gastric by-pass/stapling	❑	❑	Radial keratotomy, LASIK, or PRK
❑	❑	Angiography, angioplasty, arteriography	❑	❑	Hair growing or transplant	❑	❑	Radiation therapy, x-ray therapy
❑	❑	Appendectomy	❑	❑	Hemorrhoidectomy	❑	❑	Reconstructive plastic surgery
❑	❑	Banding hemorrhoids	❑	❑	Hernias	❑	❑	Shock therapy (ECT)
❑	❑	Bronchoscopy	❑	❑	Hysterectomy	❑	❑	Spinal anesthesia
❑	❑	Cardiac catheterization	❑	❑	Injection or implants in breasts	❑	❑	Telemedicine
❑	❑	Cesarean section # per year: ______________	❑	❑	Insertion of intrauterine contraceptive devices	❑	❑	Thoracic surgery
❑	❑	Chelation therapy	❑	❑	Laparoscopy	❑	❑	Tonsilectomy
❑	❑	Chemabrasion	❑	❑	Lasers used in therapy or surgery	❑	❑	Tubal ligation
❑	❑	Cosmetic plastic surgery or procedures (elective)	❑	❑	Liposuction, SAL	❑	❑	Vascular surgery
❑	❑	Cryosurgery	❑	❑	Needle biopsy (breast, kidney, prostate)	❑	❑	Vasectomy
❑	❑	D&C	❑	❑	Obstetrical deliveries at other than a licensed acute care hospital	❑	❑	V.B.A.C.'s # per year:______________
❑	❑	Dermabrasion	❑	❑	Obstetrical deliveries # per year: ______________	❑	❑	Weight control surgery
❑	❑	Endoscopic procedures	❑	❑	Office x-rays	❑	❑	Any procedures not customary to specialty: ______________
❑	❑	ERCP	❑	❑	Open reduction of fractures	❑	❑	______________

V. Hospital Priveleges

Have your hospital privileges been expanded during the last 12 months to include procedures for which you completed additional training required by the state licensing board and/or your specialty board? If "Yes," explain: ______________________________	❑ Yes	❑ No

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VI. Additional Professional Information

Please provide a complete explanation of "Yes" answers at the end of this section

A.	Have you ever had any professional liability insurance refused, canceled or non-renewed?	❑ Yes	❑ No
B.	Do you work as an emergency room physician, other than for maintaining hospital privileges?	❑ Yes	❑ No
C.	Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director or attending physician of any of the following? Please circle as applicable. Hospital, Sanitarium, Nursing Home, Surgi-Center, Clinic with bed and board facilities, Laboratory (independent or outside), Blood Bank, Prepaid Health Plan or Health Maintenance Organization, Other medical facilities If you have answered "Yes"/circled any of the foregoing, please list the names of the facilities and your affiliation with them in the space provided at the end of this section.	❑ Yes	❑ No
D.	Do you practice medicine at this/these institution(s)? Please explain.	❑ Yes	❑ No
E.	Do you maintain any overnight patient facilities in your own office?	❑ Yes	❑ No
F.	Do you render patients unconscious for treatment in your office or other non-hospital facility?	❑ Yes	❑ No
G.	Do you ever enter into arbitration or similar agreements with your patents? If "Yes," submit copies and describe circumstances in which they are used.	❑ Yes	❑ No

Explanations:

____

VII. Previous Insurance

Attach current letter(s) from prior carrier(s), verifying claims reported during the last ten (10) years.

Have you ever been without insurance? If "Yes," explain: ____	❑ Yes	❑ No
To your knowledge have you ever been insured with an insolvent carrier? If "Yes," explain: ____	❑ Yes	❑ No

VIII. Claims Information

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? If "Yes," complete a claims supplement for each claim.	❑ Yes	❑ No

Total Number of Claims: _________________________ Open / Reserved: _________________________ Closed: ___________________________

Brief explanation of claims:

____

IX. Prior Acts Coverage

You are not eligible for Prior Acts Coverage unless you maintained continuous claims-made professional liability insurance with your own limits of liability during the entire requested Retroactive or Prior Acts Coverage period. You must provide a complete copy of your expiring professional liability policy Declarations Page.

NOTE: Prior Acts Coverage is subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting coverage from your current carrier until you are specifically notified in writing that your request for Prior Acts Coverage has been approved.

Requested Retroactive Date: ____________________

NOTE: The requested retroactive date must equal the retroactive date on your current policy. The period between the requested retroactive date and requested effective date defines the prior acts period.

X. Practice History

Did you practice with other physicians in an employer-employee relationship, ostensible or formal partnership, professional association or medical corporation during the period for which you are requesting Prior Acts Coverage? If "Yes," list the full name(s) of the entity(ies) and physician(s) with whom you practiced and the period of each such association. Attach additional pages as needed. ____	❑ Yes	❑ No
Non-Physician Health Care Providers Desiring Coverage Did you employ, contract with or supervise any non-physician health-care providers (i.e., physician assistants, nurse practitioners, CNM's, CRNA's, etc.) during the period for which you are requesting Prior Acts Coverage? Profession(s) ______________________ Total Number ______________________	❑ Yes	❑ No
Changes in Practice: Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in this Application for Medical Professional Liability Claims-Made Coverage? For instance, did your practice formerly include obstetrical care or emergency room services that you are no longer providing, or did you ever perform silicone implants of any kind? If "Yes," please describe the changes in your practice, including all applicable dates. ____	❑ Yes	❑ No
Did any of your policies contain any coverage restrictions? If "Yes," please describe the coverage restrictions, including all applicable dates. Attach additional pages as needed. ____	❑ Yes	❑ No

NOTE: Adequate Prior Acts Coverage is contingent upon your description of your former practice.

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on page 16 of this Application to (present date) have been reported to my current insurance carrier:

Carrier: ____

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, or should be aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to my current carrier prior to the effective date of such coverage and are listed previously or by supplemental form attached below.