GeneralStar™

RENEWAL APPLICATION
PROFESSIONAL LIABILITY INSURANCE

☐ General Star Indemnity Company
☐ General Star National Insurance Company

PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE

Please complete this application in ink and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

INSTRUCTIONS TO THE APPLICANT:

Your coverage cannot be renewed without this application completed in its entirety. If this application is not received by the Company, your coverage will expire at the end of your current policy period. Please answer all questions. If space is not sufficient to fully answer a question, attach a separate page.

I. GENERAL INFORMATION

Social Security #: ___________________________ Current GENERAL STAR Policy #: _____________________

Applicant's Name: ____ Date of Birth: _______________

Professional Designation: ☐ M.D. ☐ D.O. ☐ D.P.M. ☐ Other (describe) ___________________________

1. Mailing Address: ____
   Street/P.O. Box City County State Zip Code
2. Primary Practice Location: ____ Number of years at this location: ______
   Street City County State Zip
3. Do you have more than one practice location? **If YES**, on a separate sheet please provide the following information: location address, hours of operation, procedures performed at each location, number of years at each location. ☐ Yes ☐ No
4. Office Telephone: _____________________________ E-mail: ________________________________
   Office facsimile: ______________________________ Web Site: _______________________________
5. Applicant is a(n): ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership
   ☐ Employed Physician By Whom ____
   ☐ Other (describe): ____
   Practice is a: ☐ Solo Practice ☐ Group Practice
   Entity Name: _______________________________________ Applicant's percentage of ownership: ____%
   How many other physicians practice at this entity? _______
   Do you use any "doing business as" (d/b/a) name? ☐ Yes ☐ No
   If YES, specify: ____
6. Residence Address: ____
   Street/P.O. Box City County State Zip Code
   Residence Telephone: ________________________

II. PRACTICE INFORMATION

MEDICAL SPECIALTY:	SUB-SPECIALTY:
AVERAGE WEEKLY PATIENT ENCOUNTERS :	AVERAGE WEEKLY PRACTICE HOURS:

Does your practice include the following? Check all that apply.

☐	**No Surgery**	No surgery with the exception of: suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.

☐	**Minor Surgery**	Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: ▪ Colonoscopy, sigmiodoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP), ▪ Pneumatic or mechanical esophageal dilation (not with bougie or olive), ▪ Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists who have completed a cardiovascular subspecialty training.), ▪ Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue, ▪ Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae ***No procedures performed on a patient while under general anesthesia*.**
☐	**Major Surgery**	Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography and radiation therapy. It also includes removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.
☐	**Gynecology / Obstetrics**	If checked, please indicate which procedures: ☐ Office Gynecology only ☐ Pre-natal care through 1st trimester only ☐ Pre-natal care through 2nd trimester only ☐ Pre-natal care full term ☐ Amniocentesis ☐ High Risk Pregnancies ☐ Toxemia Management ☐ Dilation and Curettage ☐ Cryosurgery ☐ Norplant Insertion ☐ Elective Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____ ☐ Therapeutic Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____
☐	**Obstetrics**	**Indicate annual number of:** ☐ Vaginal Deliveries: ______ Indicate the percentage of: Low forceps deliveries ______% Mid forceps deliveries ______% Breech Deliveries ______% ☐ Cesarean Sections: _________ ☐ VBAC Deliveries: _________ ☐ Non-Hospital Deliveries _________ (Please describe circumstances on separate sheet) ☐ Episiotomies: _________ Do you personally attend each delivery? ☐ Yes ☐ No Does a Midwife perform any actual deliveries/births? ☐ Yes ☐ No **If YES**, annual number performed by Midwife: _________
☐	**Radiology**	☐ Diagnostic ☐ Interventional Annual number of readings performed: _____________ Type of readings performed: ______________________________

III. PROCEDURES/PRACTICE SPECIFICS

Does your practice include the following (Check all that apply)?

☐	**Abortions**	Number performed per month:_____________ Where performed: ☐ Office ☐ Hospital ☐ Clinic/Other: Please list location(s) on separate page. Maximum Gestation Age? ________
☐	**Elective Plastic Surgery**	Type of Procedures: ____________________ Number performed per month: _______
☐	**Emergency Room Exposures**	Do you work in an Emergency Room? ☐ Yes ☐ No **If YES**, is this solely to satisfy requirements for hospital privileges? ☐ Yes ☐ No Indicate the average number of hours you work in the Emergency Room each month: _____________

☐ **Nursing Home(s) & Long-Term Care Facilities**	Are you an employee of - or under **any** contract to see Nursing Home patients? Provide details on a separate page.	☐ Yes ☐ No
	Do you provide medical services to patients of nursing homes, long-term care facilities or other similar entities with over-night bed & board facilities? If Yes, provide details on a separate page.	☐ Yes ☐ No
	What percentage of your practice is devoted to this type of exposure?	________%
☐ **Pregnancy Care**	Pregnancy management and care into **Second** Trimester?	☐ Yes ☐ No
	Pregnancy management and care into **Third** Trimester?	☐ Yes ☐ No
☐ **Weight Control / Bariatrics**	Any type of Weight Control and/or Bariatric Surgeries? If yes, you must provide details on a separate page.	
	Do you ☐ dispense and/or ☐ prescribe any weight control drugs? ☐ Yes ☐ No If Yes, list drug types and provide practice protocols in Comments section or separate page. What percentage of your practice is devoted to this type of exposure? _______%	

IV. MEDICALLY RELATED PERSONNEL

Do you employ, contract with, or supervise any Medical Personnel? ☐ Yes ☐ No
If YES, enter information below:

TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY	TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY
Midwife			Medical Lab Technician		
CRNA			Pharmacist		
Nurse Practitioner			Nurse (RN/LPN)		
Physician Assistant			X-Ray Technician		
Surgeon Assistant			Physical Therapist		
Optometrists			Surgeon		
Physician					

☐ OTHER (Please provide detail on separate page)

V. CHANGES in PRACTICE

HAVE YOU MADE ANY CHANGE WITHIN THE PAST TWELVE (12) MONTHS IN ANY OF THE FOLLOWING? (If yes, provide details on a separate page.)

1. Advertising; materials, types, etc.	☐ Yes ☐ No
2. Board Certification; Status change	☐ Yes ☐ No
3. Business Location(s); additions or deletions	☐ Yes ☐ No
4. Continuing Medical Education	☐ Yes ☐ No
5. Contractual Arrangements; additions or deletions	☐ Yes ☐ No
6. Medical Association/Society Membership; status change	☐ Yes ☐ No
7. Partnerships/Corporations/Association; changes, additions or deletions	☐ Yes ☐ No
8. Procedures Performed; added or discontinued	☐ Yes ☐ No
9. Specialty; modified, added, etc.	☐ Yes ☐ No
10. Other, specify	☐ Yes ☐ No

VI. PRIOR POLICY AND LOSS INFORMATION UPDATES

HAVE YOU MADE ANY CHANGE WITHIN THE PAST TWELVE (12) MONTHS IN ANY OF THE FOLLOWING? (If yes, provide details on a separate page.)

1. Has your medical or narcotics license been suspended, denied, revoked, restricted, or is currently under review of investigation by any state?	☐ Yes ☐ No
2. Have you been diagnosed with or treated for, alcoholism, drug addiction, a mental or chronic physical illness?	☐ Yes ☐ No
3. Have you been indicted or charged in a criminal suit?	☐ Yes ☐ No

		Yes	No
4.	Have your hospital privileges been suspended, denied, revoked, restricted or placed in probationary status?	☐ Yes	☐ No
5.	Have any fee or professional relations complaints been alleged against you with your medical association(s), hospital(s) or any state licensing authority?	☐ Yes	☐ No
6.	Have any claims been made against you, suit papers served upon you, or any other demands for money resulting from a medical incident?	☐ Yes	☐ No
	a. If "Yes", have these been reported to and acknowledged by **GENERAL STAR**?	☐ Yes	☐ No
	b. If "Yes", have these been reported to any other current or prior insurance carrier?	☐ Yes	☐ No
7.	Do you have knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services that might reasonably result in a claim, that have **not** been reported to **GENERAL STAR** or a prior insurance carrier? If "Yes", a CLAIM INFORMATION SUPPLEMENT <u>must</u> be completed for each incident referenced. ► **When facts or circumstances that relate to a medical incident(s) that might reasonably result in a claim are disclosed in response to this question and any accompanying Claim Information Supplement, there will not be coverage for any claims made against you arising from those facts or circumstances under any General Star policy that becomes effective on or after the date of the disclosure.** ► **The disclosure of facts or circumstances that relate to medical incident(s) that might reasonably result in a claim in response to this question or in any accompanying Claim Information Supplement DOES NOT constitute notice to General Star for claim reporting purposes under your current General Star policy.** ► **In order to report a claim, the reporting requirements in your current General Star policy must be followed. Please review your current policy for claim or incident reporting requirements.**	☐ Yes	☐ No
8.	Has any prior claim(s) been adjudicated, settled, closed, dismissed or otherwise changed in status? If Yes, please complete a CLAIM INFORMATION SUPPLEMENT.	☐ Yes	☐ No

VII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and

2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):

   ☐ Substance Impairment Supplemental Application
   ☐ Correctional Facility Supplemental Application
   ☐ Bariatric Surgery Supplemental Application
   ☐ Statement of No Known Claims Letter
   ☐ Claim Information Supplemental Application
   ☐ Other ______________________________

3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:

   a. Accurate, true and complete to the best of your knowledge;
   b. No material facts have been suppressed or misstated;
   c. Representations you are making on behalf of all persons and entities proposed to be insured;
   d. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.

4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.

5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

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.

FRAUD WARNING (not applicable in Nebraska, Vermont or Virginia): Any person who knowingly and with the 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where General Star National Insurance Company is "non-admitted or "surplus lines"), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

____________________________________ ____________________

Signature of Applicant Date

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Print or Type Name and Title