SUPPLEMENTAL APPLICATION
PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE
SUBSTANCE IMPAIRMENT

This supplemental application must be completed, signed and dated by any applicant who has suffered impairment as a result of substance abuse.

Instructions to the Applicant.

A. Please answer **all** the questions on this supplemental application. The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.

B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.

C. The application must be signed and dated by you.

I. GENERAL INFORMATION

1. Applicant's Name: Social Security No.

2. Please specify the addiction for which you have been treated:
   - ☐ Alcohol
   - ☐ Amphetamines
   - ☐ Cocaine
   - ☐ IV Opiates/Narcotics
   - ☐ Other (specify): ______________________________

3. a. Are you currently participating in a treatment program? ☐ Yes ☐ No
   b. **If YES**, does the program include random drug screening? ☐ Yes ☐ No

4. Please provide the following information regarding your treatment program:
   Name of Program: ______________________________
   Location: (street address, city, state) ______________________________
   Monitoring Physician (Name, Business Phone): ______________________________

5. a. Please describe the status of your treatment program:
   - ☐ None or non-completion
   - ☐ Outpatient
   - ☐ Inpatient less than 1 month
   - ☐ Inpatient more than one month. Length of stay: ________
   - ☐ Other (specify): ______________________________

   b. If you have completed the treatment program, please specify the completion date: ________________
   c. If you have completed a treatment program, have you experienced any relapses? ☐ Yes ☐ No
   d. **If YES**, describe the number of times and the circumstances:
   ____ ________ times

6. a. Are you participating in a 12-step program? ☐ Yes ☐ No
   b. **If YES**, Number of meetings attended weekly: __________________

7. Please specify the length of your sobriety:
   - ☐ Less than six months
   - ☐ Six months to one year
   - ☐ One to two years
   - ☐ Two to three years
   - ☐ Three to four years
   - ☐ Four to five years
   - ☐ More than five years

8. Please describe any licensure, legal or criminal actions have been taken against you to date:
   ____
   ____
   (Use additional sheet if necessary)

II. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

______________________ ______________________ ______________________
Signature of Applicant | Print or Type Name | Date (month-day-year)