GenStar

RENEWAL APPLICATION

PROFESSIONAL LIABILITY

PHYSICIANS AND SURGEONS
Claims-Made and Reported Coverage

Please complete this application 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. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

INSTRUCTIONS TO THE APPLICANT:

- You must provide a fully completed application, signed and dated by you within 45 days of the desired effective date of coverage.
- Appropriate Supplementary Applications, Claim Information Supplement(s) and additional documentation must also be completed as needed.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.

I. GENERAL INFORMATION

1	Applicant Name:		Date of Birth:
	Professional Designation: ☐ M.D. ☐ D.O. ☐ D.P.M. ☐ Other (describe):		
2	Applicant Type: ☐ Individual ☐ Corporation ☐ Partnership ☐ LLC Employed Physician - by whom: ☐ Other (describe):		
	Practice Type: ☐ Solo Practice ☐ Group Practice		
	Entity Name:		
	How many other physicians practice at this entity?	Applicant's percentage of ownership: %	
	"Doing business as" (d/b/a) names used? If **YES**, specify:		☐ Yes ☐ No
	Do you want this entity covered?		☐ Yes ☐ No
3	Mailing Address:		
	City:	County:	
	State:	ZIP:	
4	Primary Practice Location:		Number years at location:
	City:	County:	
	State:	ZIP:	
	Do you have more than one practice location? If **YES**, please provide the following for each location: location address, hours of operation, procedures performed, number of years at location:		☐ Yes ☐ No
5	E-mail:		Office Phone:
	Web Site:		Office Fax:
6	Residence Address:		Residence Phone:
	City:	County:	
	State:	ZIP:	

II. PRACTICE INFORMATION

Medical Specialty:	Average Weekly Patient Encounters:
Sub-Specialty:	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, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography
- (ERCP),
- Pneumatic or mechanical esophageal dilation (not with bougie or olive),
- Angiography; Arteriography; Catheterization - arterial, cardiac or diagnostic,
- Needle biopsy - including lung, breast, prostate and superficial and subcutaneous tissue,
- Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae

Any procedure performed on a patient while under general anesthesia is not considered Minor Surgery.

☐ **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 an operation. 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	☐ Elective Abortions
☐ Pre-natal care through 1st trimester only	Number each month:
☐ Pre-natal care through 2nd trimester only	Maximum Gestation Age:
☐ Pre-natal care full term	Where performed:
☐ Amniocentesis	☐ Therapeutic Abortions
☐ High Risk Pregnancies	Number each month:
☐ Toxemia Management	Maximum Gestation Age:
☐ Dilation and Curettage	Where performed:
☐ Cryosurgery	

Obstetrics

Indicate number of:	Vaginal Deliveries:	Indicate percentage of:	Low forceps deliveries:
	Cesarean Sections:		Mid forceps deliveries:
	VBAC Deliveries:		Breech Deliveries:
	Non-Hospital Deliveries:		

Non-Hospital Deliveries: Describe circumstances:

Does a Midwife perform any actual deliveries/births? If **YES**, annual number performed by Midwife: ☐ Yes ☐ No

Radiology - ☐ Diagnostic ☐ Therapeutic ☐ Interventional

Annual number of readings performed: Type of readings performed:

III. PROCEDURES/PRACTICE SPECIFICS

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

☐	Emergency Room Exposures - Do you work in an Emergency Department?	☐ 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 Department each month:	☐ Yes ☐ No
☐	Nursing Home(s) & Long-Term Care Facilities - Are you an employee of, or under any contract to see Nursing Home patients? If YES, 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 and board facilities? If YES, provide details on a separate page	☐ Yes ☐ No
	What percentage of your practice is devoted to this type of exposure?	☐ Yes ☐ No
☐	Hospital Privileges - Do you have hospital privileges? If YES, where?	☐ Yes ☐ No
☐	Weight Control / Bariatrics - Any type of Weight Control and/or Bariatric Surgeries? If YES, you must provide details on a separate page.	☐ Yes ☐ No
☐	Do you ☐ dispense and/or ☐ prescribe any weight control drugs? If YES, list drug types and provide practice protocols on separate page.	☐ Yes ☐ No
☐	What percentage of your practice is devoted to this type of exposure? %	☐ Yes ☐ No

IV. MEDICALLY RELATED PERSONNEL

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

TYPE	Number Employed	Number Supervised Only	Type	Number Employed	Number Supervised Only
Midwife			Medical Assistant		
CRNA			Medical Lab Technician		
Nurse Practitioner			Pharmacist		
Physician Assistant			Nurse (RN/LPN)		
Surgeon Assistant			X-Ray Technician		
Optometrists			Physical Therapist		

Other (Please Provide Detail:

V. CHANGES IN PRACTICE

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 or 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 matter?	☐ 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 providing medical professional service(s)? If YES, answer questions below.	☐ Yes ☐ No
	a Have these been reported to and acknowledged by General Star?	☐ Yes ☐ No
	b Have these been reported to any other current or prior insurance carrier?	☐ Yes ☐ No
7	Do you have knowledge of a specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, that has not been reported to General Star or a prior insurance carrier? If Yes, a Claim Information Supplemental Application must be completed for each incident referenced. ► When acts, omissions or circumstances that relate to a professional service(s) that might reasonably result in a claim are disclosed in response to this question and any accompanying Claim Information Supplemental Application, there will not be coverage for any claims made against you arising from those acts, omissions or circumstances under any General Star policy that becomes effective on or after the date of the disclosure. ► The disclosure of acts, omissions or circumstances that relate to a professional service(s) that might reasonably result in a claim in response to this question or in any accompanying Claim Information Supplemental Application 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 potential claim reporting requirements.	☐ 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)	
	☐ Part-time Supplemental Application	☐ Statement of No Known Claims Letter
	☐ Claim Information Supplemental Application	☐ Other (specify):
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 and no material facts have been suppressed or misstated;	
	b Representations you are making on behalf of all persons and entities proposed to be insured;	
	c 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.

FRAUD WARNING

Notice to Applicants of all states except New Jersey, New York, Pennsylvania, and Washington D.C.:

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 material 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 the person to criminal and civil penalties and denial of insurance benefits.

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 York Applicants:

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 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 provision.

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 a 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 Washington D.C. 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.

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.

The applicant must sign this Application within 45 days prior to the policy inception date.

Signature of Applicant:	Date:
Print or Type Name and Title:	