GenStar

RENEWAL APPLICATION

PROFESSIONAL LIABILITY

PHYSICIANS AND SURGEONS
Claims-Made and Reported Coverage

Please complete this application and answer all questions. 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. If a question is not applicable, state "N/A". If more space is required to answer a question, please use the "Other" space at the end of this form. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

I. GENERAL INFORMATION

Applicant Name: _____

Primary Practice Location: _____

City: _____

State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____

II. PRACTICE INFORMATION

1. Have there been any changes to your practice in the past 12 months? For example, new practice location, new procedures. If YES, describe in Other section below.	☐ Yes ☐ No
2. Do you expect any changes to your practice in the next 12 months? For example, discontinued procedures. If YES, describe in Other section below.	☐ Yes ☐ No
3. Do you provide any non-FDA approved treatments, for example, stem cells? If YES, describe in Other section below.	☐ Yes ☐ No
4. What percentage of your practice is for care at Nursing Homes, Long Term Care or other similar Residential Facilities?	
5. What percentage of your practice is Correctional Medicine?	
6. How many patients have you prescribed opioids to in the last 12 months?	
7. How many hours do you work per month in an Emergency Department?	
8. Average weekly patient enounters?	
9. Average weekly practice hours?	

III. LOSS INFORMATION UPDATE

In the last 12 months:

1. Has your medical or DEA license been suspended, denied, revoked or restricted or is it currently under review or investigation by any state or licensing authority?	☐ Yes ☐ No
2. Have you been diagnosed with or treated for any substance abuse issue, or for any chronic mental or physical illness?	☐ Yes ☐ No
3. Have you or any of your staff been the subject of any abuse or molestation allegations?	☐ Yes ☐ No
4. Have you been indicted or charged in any criminal matter?	☐ Yes ☐ No
5. Have your hospital privileges been suspended, denied, revoked, restricted or placed on probationary status?	☐ Yes ☐ No
6. Have any fee or professional relations complaints been alleged against you or any of your staff with your medical associations, hospitals or any state licensing authorities?	☐ Yes ☐ No
7. Have any claims been made against you, suit papers served upon you, or have you received any demands for money resulting from providing medical professional services?	☐ Yes ☐ No
If YES, please confirm that these have been reported to the Claims Department at General Star or to a prior insurance carrier and complete a Claim Supplement Form.	☐ Yes ☐ No
8. Do you have knowledge of a specific act, omission or circumstance involving specific medical professional services that may result in a claim?	☐ Yes ☐ No
If YES, please confirm that these have been reported to the Claims Department at General Star or to a prior insurance carrier and complete a Claim Supplement Form.	☐ Yes ☐ No

IV. OTHER

V. 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 Supplement 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: