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PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION

I. GENERAL INFORMATION (if additional space is needed, please attach a separate sheet of paper.)

1. If my application is approved, my requested coverage date is _____ at 12:01am

2. _____
First Name Middle Name Last Name MD/DO Last 4 Digits of Social Security Number

3. ____/____/____ 4. _____
Date of Birth Place of Birth Driver's License Number and State of Issue

5. List practice locations including all offices, nursing homes, urgent care clinics and all other non-hospital locations (list principal location first):

a. _____
Number & Street Suite City State Zip County % of Practice Type of Location

Business Phone Number Fax Number E-mail Address Website Address

b. _____
Number & Street Suite City State Zip County % of Practice Type of Location

c. _____
Number & Street Suite City State Zip County % of Practice Type of Location

6. _____
Home Address City State Zip County Home Phone

7. Desired mailing address: Home _____ Office _____ Other _____

Furnish billing address if different from mailing address:

Number & Street Suite City State Zip County

8. State(s) in which you hold a license to practice medicine:

State License Number Status

State License Number Status

State License Number Status

State License Number Status

9. Medical Associations or Societies to which you belong: _____

Number of CME credits you have obtained in the last two years: _____

10. If you switch to MAG Mutual, do you want us to also cover your medical acts for the period you were insured with your present carrier (Prior Acts Coverage)? Yes _____ No _____

If "Yes", please complete a supplemental application for physicians requesting coverage for acts occurring prior to the effective date of this policy. If "No", will you purchase an extended reporting endorsement (tail coverage) that provides coverage for the acts occurring prior to the effective date of this policy from your current carrier? Yes _____ No _____

II. EDUCATIONAL BACKGROUND

1. _____
 Medical School _____ State _____ Country _____ Year Graduated _____

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates?

Yes _____ No _____ Not applicable _____

Have you passed the FLEX?

Yes _____ No _____ When _____ Not applicable _____

Have you passed the USMLE?

Yes _____ No _____ When _____ Not applicable _____

2. Names, locations and dates of internships and/or residencies served:

Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

a. Did you successfully complete your residency training? Yes _____ No _____

If not, explain why: _____

b. Explain any additional years spent in a residency program: _____

c. Explain any gaps in time from date of medical school graduation to completion of residency: _____

3. Additional training (fellowship, etc.):

Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Institution	Location	Special Program	Mo./Yr. to Mo./Yr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Are you currently a resident, intern or fellow: Yes _____ No _____ If "Yes", date you will complete training: _____

5. a. Are you certified by an approved specialty board? Yes _____ No _____

Certifying Board	Cert.	Elig.	Date Certified	*Date Eligibility Expires
_____	()	()	_____	_____
_____	()	()	_____	_____

Certifying Board	Cert.	Elig.	Date Certified	*Date Eligibility Expires
_____	()	()	_____	_____
_____	()	()	_____	_____

*If eligible for over five years but not certified, please explain: _____

b. Have you ever failed a Board exam? Yes _____ No _____ If yes, how many times on each part? _____ oral _____ written

III. PHYSICIAN UNDERWRITING INFORMATION

It is necessary that this section be completed by the physician applicant.

1. _____
 Name of current professional liability insurance company (enclose copy of Introduction Page or Declaration Page) / # of years with carrier / current premium

2. What is the date that your current policy will expire? _____

3. If your answer to any of the following is "Yes," give details on a separate signed and dated sheet of paper. **If your answer to "e" and/or "f" is "Yes" it is also necessary to complete the Underwriting Claim Investigation form for each claim.**

- a. Has your license to practice medicine in any state or country or your permit to prescribe drugs ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation? Yes _____ No _____
- b. Have you ever been or are you currently under a Consent Order or agreement with any state licensing board of medical examiners, DEA, or governmental agency (public or private)?
If "Yes", attach a copy of the applicable documents. Yes _____ No _____
- c. Have your hospital staff or other healthcare facility privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered, subject to involuntary monitoring, in any other way restricted, or have they been or are they currently under investigation? Yes _____ No _____
- d. Has any insurance company (including Lloyd's of London) ever canceled, declined to issue or refused to renew your medical professional liability insurance, or offered such insurance only on special terms, such as an involuntary deductible or surcharge, or have you been notified of such intent? (Enclose copy of Cancellation Notice or Letter if applicable.) Yes _____ No _____
- e. Has any civil action or claim ever been filed against you or have you been notified that any civil action or claim will be filed against you alleging medical errors or omissions? Yes _____ No _____
- f. Have any judgments been made against you, or any out-of-court settlements been made on your behalf or as a result of your alleged act or omission from an incident alleging medical negligence, errors or omissions? Yes _____ No _____
- g. Have you ever been convicted of a criminal offense or are you under investigation for a criminal offense? Yes _____ No _____
- h. Have you been treated or evaluated for alcoholism, narcotics or other substance abuse, sexual addiction/misconduct, anger management issues or any other mental illness? (Provide dates and locations of all treatments or evaluations, and the names of your supervising and monitoring physicians.) Yes _____ No _____
- i. Have you received psychiatric/psychological treatment or evaluation during the last 10 years (other than in the course of your training or in family/marital counseling)? Yes _____ No _____
- j. Have you become aware of any illness or physical defect, or have you received any major medical/surgical treatment or evaluation in the last 10 years? Yes _____ No _____
- k. Do you enter into any oral or written contract or agreement guaranteeing the result of any treatment or operation performed by you, personally, or performed under your supervision? Yes _____ No _____
- l. Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? Yes _____ No _____
- m. Has your involvement in any health program (e.g. Medicare, Medicaid, HMOs, PPOs, or other managed care provider) ever been suspended, placed on probation, terminated, or limited in any way? Yes _____ No _____

4. a. Check (✓) type of practice for which you are applying:
- | | | |
|---|--|---|
| <input type="checkbox"/> Solo Physician | <input type="checkbox"/> Partnership (include name) | <input type="checkbox"/> Professional Association |
| <input type="checkbox"/> Solo Medical Corporation | <input type="checkbox"/> Use of assumed name (DBA) | <input type="checkbox"/> Locum Tenens |
| <input type="checkbox"/> Professional Corporation | <input type="checkbox"/> Group Member (include name) | (substitute or temporary physician) |
| <input type="checkbox"/> Independent Contractor | <input type="checkbox"/> Resident/Fellow-Program | <input type="checkbox"/> Employed Physician |
| | | (include name of employer) |

If you checked any boxes above other than "Solo Physician", list below the name of Applicable entity(ies) and/or any physician(s).

Name(s) Entity(ies)	Name(s) of Employer(s)	Professional Liability Insurance Carrier(s)	Employment/Contract Date (mm/dd/yy) to (mm/dd/yy)
_____	_____	_____	_____
_____	_____	_____	_____

- b. Are you applying for coverage for any of the above entities? Yes _____ No _____
- If "Yes", which one(s): _____
- Please submit a copy of the Corporate Charter. (Verification of the legal name and ownership.)

Other Physicians: Do you practice with other physicians not listed above? Yes _____ No _____

If "Yes", list the physician(s) with whom you practice and describe the association.

Physician(s)	Association
_____	_____
_____	_____

5. a. _____
Your Primary Medical Specialty **Your Sub-specialty (if applicable)**
- b. Is your practice limited to your sub-specialty? Yes _____ No _____
- c. Do you perform any procedures not routinely performed by physicians in your specialty or sub-specialty? Yes _____ No _____
 If "Yes", please explain _____

6. Describe your intended medical practice for which you are applying: _____
- a. Have your practice specialties and/or procedures changed in the past 5 years? Yes _____ No _____
- b. Are you planning any changes to the nature and/or extent of your practice within the next 12 months? Yes _____ No _____
- c. Are you planning to add any additional procedures to your practice within the next 12 months? Yes _____ No _____
 If "Yes" to either, please explain _____

7. Do you perform any work, either full-time or part-time, for any state government or the federal government? Yes _____ No _____
 If "Yes", please describe: _____

8. Are you on active duty in the U.S. military service? Yes _____ No _____

9. a. Locations and dates of practice (account for all time including military and faculty):
 (Attach a copy of your most recent curriculum vitae.)

_____	_____	_____	_____
Dates	Location	Dates	Location
_____	_____	_____	_____
Dates	Location	Dates	Location
_____	_____	_____	_____
Dates	Location	Dates	Location

- Was any of this time for Obligatory Payback? Yes _____ No _____
- b. Were any of the above less than full-time? Yes _____ No _____ If yes, explain: _____
- c. Explain any gaps in employment history and any period(s) that you were uninsured: _____

10. Are you part-time/semi-retired? Yes _____ No _____ If "Yes", and you are requesting Prior Acts Coverage, enclose a copy of proof that you are currently eligible for a part-time/semi-retired discount with your current carrier. **Additionally, please request a part-time/semi-retired application.**

11. a. Are you engaged in any "moonlighting" activities? Yes _____ No _____
 If "Yes", number of hours per month: _____ Organization: _____
 Please describe such activities: _____
 Will you maintain professional liability insurance with other insurance companies for moonlighting activities? Yes _____ No _____
 If "Yes", name of insurance carrier (enclose copy of Introduction Page or Declaration Page): _____
- b. Are you providing any other medical services for which you do not need coverage with us? Yes _____ No _____
 If so, what type of services and who is insuring them? _____

12. a. List all hospitals and surgical centers where you currently have staff privileges or have applied for staff privileges and % of practice at each:

<u>Name</u>	<u>City/State</u>	<u>JCAHO Approved</u>	<u>Applied</u>	<u>Active</u>	<u>Courtesy</u>	<u>% of practice</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

- b. Do you provide any call coverage for physicians outside of your practice specialty? Yes _____ No _____
 If "Yes", please explain: _____
- c. If you do not have admitting privileges, please describe in detail your procedure for handling your patients who may require in-patient care: _____

13. Do you perform any surgical procedures? Yes _____ No _____ If "Yes", check (✓) all surgical/medical procedures you perform and enter the appropriate number you perform each month where indicated:

<input type="checkbox"/> Abdominal surgery _____per mo.	<input type="checkbox"/> Cranial surgery _____per mo.	<input type="checkbox"/> _____ Without Bougie or olive clip
<input type="checkbox"/> Abortions _____per mo.	<input type="checkbox"/> CT scanning __ no dye __ with dye	<input type="checkbox"/> Pneumoencephalography
<input type="checkbox"/> Where: _____	<input type="checkbox"/> C-sections _____per mo.	<input type="checkbox"/> Pre-natal care past first trimester
<input type="checkbox"/> Trimester _____	<input type="checkbox"/> Deliveries _____per mo.	<input type="checkbox"/> Radiation therapy
<input type="checkbox"/> Acupuncture _____per mo.	<input type="checkbox"/> Dilution and curettage _____per mo.	<input type="checkbox"/> Radiopaque dye injection (other than IVP) in the blood vessels, lymphatics, sinus tracts and fistulae
<input type="checkbox"/> Adenoidectomies _____per mo.	<input type="checkbox"/> Diskography	<input type="checkbox"/> Shock therapy (ECT/EST)
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> EGD	<input type="checkbox"/> Thoracic surgery _____per mo.
<input type="checkbox"/> Angiography	<input type="checkbox"/> EKG	<input type="checkbox"/> Thrombolytic Therapy
<input type="checkbox"/> Venous	<input type="checkbox"/> Endoscopies _____per mo.	<input type="checkbox"/> Tonsillectomies _____per mo.
<input type="checkbox"/> Arterial	<input type="checkbox"/> ERCP	<input type="checkbox"/> Trauma surgery _____per mo.
<input type="checkbox"/> Peripheral angioplasty	<input type="checkbox"/> Flexible sigmoidoscopies	<input type="checkbox"/> Tubal ligations
<input type="checkbox"/> Angioplasty _____per mo.	<input type="checkbox"/> Fluoroscopic procedures	<input type="checkbox"/> Tumor Ablation
<input type="checkbox"/> Appendectomies _____per mo.	<input type="checkbox"/> Hemorrhoidectomies	<input type="checkbox"/> Uterine Fibroid embolization
<input type="checkbox"/> Aspirations	<input type="checkbox"/> Herniorrhaphies _____per mo.	<input type="checkbox"/> Vascular surgery _____per mo.
<input type="checkbox"/> Assistance in major surgery	<input type="checkbox"/> Hysterectomies _____per mo.	<input type="checkbox"/> Vasectomies
<input type="checkbox"/> On own or group's patients only	<input type="checkbox"/> Image guided Biopsy _____per mo.	<input type="checkbox"/> Venipunctures
<input type="checkbox"/> On patients of others	<input type="checkbox"/> Injection of irradiated substances into the blood stream for diagnostic purposes (IVPs)	<input type="checkbox"/> Vertebroplasty _____per mo.
<input type="checkbox"/> Back/spinal surgery _____per mo.	<input type="checkbox"/> Laminectomies _____per mo.	<input type="checkbox"/> Other surgeries/no. _____per mo.
<input type="checkbox"/> Bariatric surgery _____per mo.	<input type="checkbox"/> Laparoscopic cholecystectomies _____per mo.	_____
<input type="checkbox"/> Cosmetic	<input type="checkbox"/> Laparoscopic laser surgery _____per mo.	_____
<input type="checkbox"/> Medical necessity	<input type="checkbox"/> Laparoscopy (peritoneoscopy)	<input type="checkbox"/> List of endoscopies performed
<input type="checkbox"/> Breast implants	<input type="checkbox"/> Laparoscopy (peritoneoscopy)	_____
<input type="checkbox"/> Cardiac catheterization	<input type="checkbox"/> Large Core Needle Biopsy	_____
<input type="checkbox"/> Diagnostic coronary angiography	<input type="checkbox"/> Liposuction _____per mo.	_____
<input type="checkbox"/> Left heart catheterization	type _____	<input type="checkbox"/> Administer or supervise anesthesia (If so, complete question 17)
<input type="checkbox"/> Permanent pacemaker	area(s) of body _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> PTCA (coronary angioplasty)	<input type="checkbox"/> Lumbar puncture	_____
<input type="checkbox"/> Cardiac surgery _____per mo.	<input type="checkbox"/> Lymphangiography	_____
<input type="checkbox"/> Cast (set)	<input type="checkbox"/> Mammography _____per mo.	_____
<input type="checkbox"/> Cholecystectomies _____per mo.	<input type="checkbox"/> Myelography	_____
<input type="checkbox"/> Circumcisions (other than newborn)	<input type="checkbox"/> Neo-natal intensive care visits	_____
<input type="checkbox"/> Closed reductions of fracture _____per mo.	<input type="checkbox"/> Phlebography	_____
<input type="checkbox"/> Colonoscopies/sigmoidoscopies	<input type="checkbox"/> Open reductions _____per mo.	_____
<input type="checkbox"/> Cryosurgery on malignant lesions	<input type="checkbox"/> Orthopedic surgery _____per mo.	_____
<input type="checkbox"/> Cosmetic surgery (elective) _____per mo.	<input type="checkbox"/> Pneumatic or mechanical esophageal dilation	_____
<input type="checkbox"/> Detail each type and number per type _____	<input type="checkbox"/> _____	_____
_____	<input type="checkbox"/> With Bougie or olive clip	_____

14. Non-Hospital Procedures: Of those surgical procedures listed above, list all performed in your office, surgicenter or other non-hospital facility:

Procedure	#Weekly	Where Performed	Do you have privileges at an accredited hospital for this procedure?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- a. Do you perform procedures in a non-hospital setting where other than local anesthesia is administered? Yes _____ No _____
If "Yes", type(s) used: _____
- i) Location () Office () Surgicenter () Other Non-Hospital Facility
- ii) Who administers the anesthesia? _____

- b. Are these facilities accredited by the Accreditation Association for Ambulatory Healthcare or any similar organization?
Yes _____ No _____

c. For surgicenter or other non-hospital facility, please provide the name and address of each.

d. Do you maintain a surgical suite(s) at any of the practice locations listed on page 1, question number 5 or at any other location?

Yes _____ No _____ If "Yes", explain: _____

e. Do you maintain a full emergency cart? Yes _____ No _____

i) Do you follow a protocol for checking a cart on a regular basis? Yes _____ No _____

ii) Are the checks documented? Yes _____ No _____

15. Do you own (Yes ___ No ___) or use (Yes ___ No ___) surgical center facilities?

If "Yes", name & location of facility: _____

If you own a surgical center, does anyone other than you or members of your organization use this facility? Yes _____ No _____

16. a. Do you normally staff an emergency room other than on rotational call? Yes _____ No _____

If "Yes", how often? _____

b. Do you normally take on-call rotation in the ER? Yes _____ No _____

When on call, frequency of rotation and average hours in the ER per month: _____

Are you certified? ACLS _____ Exp. date ATLS _____ Exp. date PALS _____ Exp. date

17. TO BE COMPLETED IF YOU ADMINISTER ANY ANESTHESIA OR SUPERVISE ADMINISTRATION OF ANY ANESTHESIA (IF NOT CONTINUE TO NO. 18):

Do you perform pain management only? Yes _____ No _____

Do you administer anesthesia only as an anesthesiologist? Yes _____ No _____

Do you supervise an anesthesiology department? Yes _____ No _____

What is the maximum number of anesthetic assistants you supervise at any one time? _____

Are you always present during intubation and initial dosing by anesthetic assistants? Yes _____ No _____ N/A

Are you ever off premises while supervising anesthetic assistants? Yes _____ No _____ N/A

Are the anesthetic assistants you supervise hospital/facility employees? Yes _____ No _____ N/A

If "Yes", are they also supervised by a physician anesthesiologist if you are a surgeon? Yes _____ No _____ N/A

If not hospital/facility employees, who is the employer? _____

Do you administer any anesthesia as a surgeon? Yes _____ No _____

Do you work with, or have you ever worked with, a chiropractor who performs manipulation under anesthesia? Yes _____ No _____

If "Yes" to any of the above, explain: _____

18. Do you perform chelation therapy? If so, for what reasons? _____

19. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunication, video, or information systems? If so, please describe: _____

20. Do you provide medical professional services to correctional institution inmates (i.e. federal or state prisons, county jails, or youth detention centers)? _____ No. of hours per month? _____

21. Does your practice involve weight reduction or control, other than prescribing exercise? _____ Yes _____ No _____
(Percentage of patients exclusively for weight reduction or control _____%)

If "Yes", please explain fully including name of medication(s) prescribed or dispensed or surgery performed:

22. Do you supervise residents? If "Yes", please explain below. Yes _____ No _____

23. Do you provide medical professional services to any members of a professional or collegiate sports team or organization? Yes _____ No _____
- a. If "Yes", which professional team(s)/organization(s) do you provide these services to?

- b. If "Yes", what is your title or role with the team(s)/organization(s) (volunteer, team physician, etc.)?

24. Do you perform or provide supervision for others performing any cosmetic aesthetic procedures? Yes _____ No _____

Please indicate the number per month, location and whether personally performed. (Please submit certificates of training if applicable).

<u>Procedure</u>	<u># Per Month</u>	<u>Location*</u>	<u>Who Performs Procedure</u>
__ Botox Injections	_____	_____	_____
__ Micro Dermabrasion	_____	_____	_____
__ Laser Hair Removal	_____	_____	_____
__ Laser Skin Resurfacing	_____	_____	_____
__ Body Contouring	_____	_____	_____
__ Phototherapy	_____	_____	_____
__ Restayne Injections	_____	_____	_____
__ Other, Please Detail	_____	_____	_____

25. Do you provide medical services at any Nursing Home? If "yes", please explain: Yes _____ No _____
- _____

26. Do you have any Medical Director responsibilities? If "Yes", please list name, type and location of entity. Yes _____ No _____
- _____

27. Are you a member of the Neurological Injury Compensation Association (NICA) (Florida only) or a member of Virginia Neurological Birth Injury Fund (Virginia only)? Yes _____ No _____

28. Do you perform medical Utilization Review Management evaluations for health care organizations? Yes _____ No _____
- If "Yes", please explain: _____

29. With respect to your individual practice, what are your estimated ANNUAL numbers of the following?

(Answer personally even if you are a member of a group. Do NOT give group totals.)

Patient encounters (Office visits, X-rays, anesthesia, etc.): _____

Hospital inpatient admissions: _____

Hospital surgical procedures performed: _____

Outpatient surgical procedures performed: _____

- 30. LIMITS OF COVERAGE REQUESTED:** Check the appropriate blank.

- __ \$100,000 Each loss/\$300,000 Annual Aggregate limit (Available in Florida only)
- __ \$250,000 Each loss/\$750,000 Annual Aggregate limit (Available in Florida only)
- __ \$500,000 Each loss/\$1,500,000 Annual Aggregate limit (Available in Florida only)
- __ \$1,000,000 Each loss/\$1,000,000 Annual Aggregate limit
- __ \$1,000,000 Each loss/\$3,000,000 Annual Aggregate limit
- __ \$2,000,000 Each loss/\$4,000,000 Annual Aggregate limit (Not available in Florida)
- __ \$2,000,000 Each loss/\$6,000,000 Annual Aggregate limit (Available in Virginia only)
- __ \$3,000,000 Each loss/\$5,000,000 Annual Aggregate limit (Not available in Florida)

PLEASE ENCLOSE A COPY OF THE RENEWAL CERTIFICATE/DECLARATIONS PAGE FROM YOUR PRESENT POLICY WHICH SHOWS YOUR RETROACTIVE DATE. ATTACH YOUR CURRICULUM VITAE.

(ATTACH SEPARATE SHEET FOR ADDITIONAL ANSWERS OR EXPLANATIONS.)

*Location H=Hospital O=Office S=Surgi-Center

IV. EMPLOYEE INFORMATION

1. Do you employ and/or provide supervision for any of the following allied healthcare professionals listed below? Yes _____ No _____
 If "Yes", please include name of each, license number of each, date employed, and insurer of each.

	Name	License #	Date Employed	Insurer
Anesthetic Asst. (CRNA, PA or AA)	_____	_____	_____	_____
	_____	_____	_____	_____
Nurse Midwife (CNM)	_____	_____	_____	_____
	_____	_____	_____	_____
Nurse Practitioner (NP)/ Physician's Asst. (PA)	_____	_____	_____	_____
	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____
Optometrist (OD)	_____	_____	_____	_____
Podiatrist	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
Social Worker	_____	_____	_____	_____

2. Do you want to provide coverage for any of the above listed employees with the policy that may be issued from this application? Yes _____ No _____
 If "Yes", do you want a separate limit for them? Yes _____ No _____ If "Yes", please provide copy of their current Declarations Page and date of birth. Are they full or part-time employees? _____ Explain: _____

If "No", do you want them to share in your limits or the limits of the organization? My limits _____ Organizational limit _____

3. Do you supervise any non-employed allied healthcare professionals other than those already listed above? If yes, please explain:

4. Has any claim or lawsuit ever been brought against any of the employees listed above? Yes _____ No _____

5. Do you have a signed protocol agreement in place for any of the individuals referenced above? Yes _____ No _____

Completed by (please print): _____
 Name Title Date

V. BUSINESS INFORMATION

It is necessary to complete this section for **solo incorporated physicians and group entities** (groups should only complete one Business Information section).

1. _____
 Organization name (legal name) Policy number Date organization was formed
 (if currently insured with MAG Mutual or Professional Security Ins. Co.)

2. Chief Executive Officer: _____

3. Check only one:
 Do you want your organization to share in the physician's individual limit?
 (a shared limit of coverage requires no additional charge) Yes _____ No _____
 - or -
 Do you want a separate limit of coverage provided to the organization?
 (a separate limit of coverage requires an additional charge and requires underwriting approval) Yes _____ No _____

4. Organizational structure information:

a. Is the organization 100% physician owned? Yes _____ No _____

If "No", please explain: _____

b. Is the organization owned by an allied healthcare professional that you supervise? If so, who?

c. Does the group combine revenues, expenses and share in profits? Yes _____ No _____

d. Does the group have a centralized patient records, billing and collection system? Yes _____ No _____

e. Are all group members practicing at the principal office address? Yes _____ No _____

f. Are any physician members employed by other organizations? Yes _____ No _____

If "Yes" to "f" , please explain: _____

5. List names of all other entities to be insured, such as professional organizations of insured physicians and subsidiaries of the principal organization. Indicate if each is a corporation, partnership, joint venture, etc. (Include date of formation and where it is incorporated): _____

6. List all physicians affiliated with the organization(s) and the current insurer of each. (Use separate sheet of paper if necessary).

Name	Insurer	Name	Insurer
_____	_____	_____	_____
Name	Insurer	Name	Insurer
_____	_____	_____	_____

7. Have there been any settlements/judgments made on behalf of the organization, or are any lawsuits or claims pending? Yes _____ No _____ If "Yes", please complete Underwriting Claim Investigation form.

Completed by (please print): _____

Name	Title	Date
------	-------	------

8. Other products and services available through MAG Mutual (please check (√) those you would like more information on):

- | | |
|--|--|
| <input type="checkbox"/> Workers' Compensation Insurance | <input type="checkbox"/> Personal or Group Health Insurance |
| <input type="checkbox"/> Businessowners Insurance | <input type="checkbox"/> Billing or Transcription Services |
| <input type="checkbox"/> Employment Practices Liability Insurance | <input type="checkbox"/> Accounting and Tax Services |
| <input type="checkbox"/> Regulatory Fraud and Abuse Insurance and Consulting | <input type="checkbox"/> Pension Planning, Establishing or Managing Your IRA |
| <input type="checkbox"/> Healthcare Services Facility Insurance | <input type="checkbox"/> Disability Income Protection, Life Insurance |
| <input type="checkbox"/> Auto, Home and Personal Liability Insurance | <input type="checkbox"/> Financial and/or Estate Planning |

May we send information about our products and services to your e-mail address? Yes _____ No _____

9. How did you hear about MAG Mutual? _____

IMPORTANT – FOR YOUR OWN PROTECTION – Report immediately, and in writing, to your current insurer all incidents which might lead to a claim against you. This includes: requests for records, depositions, notices, subpoenas, complaints of patients or patients' families who threaten to bring legal action, or any other incident which might give rise to a claim from an unfavorable result in treatment.

No Prior Acts Coverage

IMPORTANT: If you have previously been insured under a claims-made policy, please read.

A claims-made policy covers claims resulting from medical professional services provided or withheld on or after the retroactive date shown on the policy and first reported while the policy is in force. If you have been insured by a claims-made policy and did not purchase the Extended Reporting Endorsement from the insurer, you are NOT insured for your acts prior to the effective date of this policy. MAG Mutual has no obligation to defend or to pay claims resulting from medical professional services provided or withheld prior to the effective date of any policy issued upon this application.

PRIOR ACTS COVERAGE MAY BE AVAILABLE, BUT REQUIRES A SUPPLEMENTAL APPLICATION AND PREMIUM.*

[*See question number 10, page 1.]

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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states and may subject the person to criminal and civil penalties.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Fla. Stat. § 817.234(1)(b).

KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. KRS § 304.47-030.

TENNESSEE and VIRGINIA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Tenn. Code Ann. § 56-53-111(b)(1)(A). Va. Code Ann. § 52-40 (2009).

IT IS NECESSARY FOR ALL APPLICANTS TO SIGN SPACES BELOW.

IMPORTANT: Incomplete or incorrect information could result in a retroactive upward premium adjustment, or could lead to a denial of coverage in the event of a claim.

I hereby declare that the statements and responses I have provided in this application are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that deliberate misstatements, which are deemed material or fraudulent, may be grounds for cancellation or denial of coverage in the event of a claim.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I understand that this is an application for insurance and not an insurance binder. I also understand that, if my application is approved, my effective date cannot be prior to the date that I have met all of the Company's requirements for issuance.

X _____
Applicant's Signature (required) Date

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance with the Company (MAG Mutual Insurance Company and Professional Security Insurance Company) hereby authorizes his/her present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request all non-privileged information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney or the Company may have a bearing upon his/her acceptability to the Company as a professional liability risk.

The undersigned also authorizes all medical associations, medical societies and managed care organizations in which he/she is or has been a member, all hospitals in which he/she now holds or has held staff privileges, the state board of medical examiners for the state in which he/she has practiced, the state department of public health for the state in which he/she has practiced or resided, motor vehicle departments, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which, in the judgment of any such person or entity, has a bearing upon his/her acceptability to the Company as a professional liability risk. The undersigned hereby agrees to hold harmless from and against any and all claims, demands and causes of action against any person or entity who releases information on his/her behalf according to this authorization. Furthermore, the undersigned agrees to hold harmless to the same extent the Company and any of its present or former employees and agents. **The undersigned acknowledges that this application may be used by the Company to underwrite coverage with MAG Mutual Insurance Company and/or Professional Security Insurance Company. Applications for Professional Security Insurance Company may be submitted only through a licensed, surplus lines broker or agent as Professional Security Insurance Company is an unauthorized insurer eligible to transact insurance in your state under applicable surplus lines insurance laws.**

X _____
Applicant's Signature (required)

By signing in the space below, you also authorize the Company or its duly authorized agents to provide a CERTIFICATE OF INSURANCE to interested parties.

X _____
Applicant's Signature (optional) Date

X _____
Agent's Name Agent's License Number