FORT WAYNE MEDICAL SURETY COMPANY
RISK RETENTION GROUP

Application for

MEDICAL PROFESSIONAL LIABILITY INSURANCE

This policy is issued by Fort Wayne Medical Surety Risk Retention Group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Return Application to:
Aon Risk Services, Inc of Indiana
201 N Illinois St, Suite 1400
Indianapolis, IN 46204
Toll-Free: (800) 828-3177
Fax: (317) 237-2461
Kristine_hughes@ars.aon.com

Fort Wayne Medical Surety Company
Risk Retention Group

RETURN APPLICATION TO:

Aon Risk Services-Attn. Kris Hughes
201 N Illinois St, Suite 1400
Indianapolis, IN 46204
Toll Free Telephone: (800) 828-3177 / -317-237-2452
Fax: 317 237-2461 E-mail: Kristine_Hughes@ars.aon.com

Application for Individual Medical professional liability insurance. A claims-made policy covers claims arising from the performance of professional services after the retroactive date shown on the policy and first brought against you while the policy is in effect. Please type or print in blue or black ink. All questions must be answered completely. If a question does not apply to you or your practice, please indicate by writing "no", "none", or "N/A" (non-applicable).

COVERAGE REQUESTED

1. Effective date of coverage requested (If approved, earliest date coverage can begin is 12:01 a.m., the day following receipt of completed application): _____ Month / Day / Year

2. Coverage desired

a.) ☐ Occurrence

b.) ☐ Claims-made **(without prior acts)**

☐ My prior coverage was Occurrence coverage

☐ My prior coverage was Claims-made, and I purchased an Extended Reporting Endorsement (Tail) see attached.

☐ My prior coverage was Claims-made, and I **DID NOT** and **WILL NOT** purchase a (Tail)
I will not purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise in the future as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am purchasing from Fort Wayne Medical Assurance Company Risk Retention Group, will not provide prior acts coverage.

Initial here: ☐

3. Please indicate Indiana Patient Compensation Fund retroactive date _____ Month / Day / Year 12:01am

4. Specialty for which this coverage would apply _____
(e.g. Family Practice)

APPLICANT INFORMATION

5. APPLICANT NAME:

_____
Last Name First Name Middle Initial Degree

6. **a.)** Date of Birth: _____ **b.)** Gender: _____

7. **a.)** Social Security #: _____ **b.)** Medical License #/State: _____

8. Office Locations (**List Principal Location First**):

_____ Telephone: _____
Street Suite

_____ Facsimile: _____
City State Zip Code County

_____ Telephone: _____
Street Suite

_____ Facsimile: _____
City State Zip Code County

9. Residential Address:

_____ Telephone: _____
Street Apt #

_____ Facsimile: _____
City State Zip Code County

Preferred Mailing Address: ☐ Office ☐ Home

10. **a.)** List all hospitals, nursing homes or outpatient facilities where you are or will be on staff, have privileges or render professional medical services, including managed care organizations. (List others on Supplemental Page)

Name	Address, City, State	Status of Privileges	Do You Want Certificate Sent?			
			Yes	☐	No	☐
			Yes	☐	No	☐
			Yes	☐	No	☐
			Yes	☐	No	☐

b.) Have you had more than 5 practice relocations, involving a change of Staff Privileges, in your practice history? Residency or military relocations do not apply. (If YES, please indicate number) _____ Yes ☐ No ☐

11. **a.)** Hours worked per week: _____

12. If you practice in a partnership, multi-member professional association or corporation, or employ other physicians - list all physicians in your practice and indicate whether partner, stock holder or employee. ***Attach a copy of practice letterhead.***

Physician Name	Shareholder	Partner	Employee	Applications Submitted? YES	NO
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Please note that if you are practicing as a partnership or as a member of an association or group, all physicians with whom you are practicing must submit applications for underwriting review even if they do not intend on insuring through the FWMAC. Additionally, there must be a majority of physicians within your partnership or group that do intend on insuring through the FWMAC for your application to be considered and accepted for coverage. Please be advised that if you are approved for coverage based on the understanding that a majority of the group will obtain insurance through the FWMAC, you may be canceled mid-term if the majority does not ultimately insure through the FWMAC, which can result in substantial loss of capital contribution and unearned premium.

13. Please indicate the number of healthcare personnel listed below that your practice employs, contracts and supervises

	How Many?	Has Own Coverage? YES	NO
ARNP-Advanced Registered Nurse Practitioners (if YES, please indicate number)	_____	☐	☐
CNM-Certified Nurse Midwives (if YES, please indicate number)	_____	☐	☐
CRNA-Certified Registered Nurse Anesthetists (if YES, please indicate number)	_____	☐	☐
PA-Certified Physician Assistants (if YES, please indicate number)	_____	☐	☐
OD-Optometrists (if YES, please indicate number)	_____	☐	☐
PhD-Psychologists (if YES, please indicate number)	_____	☐	☐
DC-Chiropractors (if YES, please indicate number)	_____	☐	☐
Other: _____ (if YES, please indicate number)	_____	☐	☐

Please note that these personnel must either have their own professional liability insurance or purchase it through this program. Please see last page of application.

If any of the above have their own professional liability insurance, attach a Certificate of Insurance.

		YES	NO
14.	Do you own or operate any medical business whether related or not to your practice? If YES, please describe the nature of the business enterprise and your affiliation (e.g., owner, employee, independent contractor etc.) with the entity. (Use additional page if necessary.)	☐	☐
15.	Are you a Medical Director of a nursing home, health care facility or any other business enterprise providing medical services?	☐	☐
	If YES, do you render patient care in your capacity as Medical Director?	☐	☐
16.	Do you evaluate medical procedures, devices, drugs, drug regimens, therapy or clinical research or perform any procedure in your medical practice that is in an experimental stage or not FDA approved? If YES, please explain. (Use additional page if necessary.) _____	☐	☐
17.	As of the requested retroactive date for coverage, have you or will you practice Telemedicine, E*Commerce Medicine or practice medicine outside the State of Indiana? If YES, please explain. (Use additional page if necessary.) _____ _____ _____	☐	☐

PERSONAL, HOSPITAL AND LICENSE INFORMATION

		YES	NO
18.	Are you now, or have you ever been, treated for the use of any of the following:		
	a) Alcohol	☐	☐
	b) Narcotics	☐	☐
	c) CNS stimulants or depressants	☐	☐
	If YES, did you submit your treating physician statement to the hospital for review?	☐	☐
19.	Are you now, or have you ever been, treated for any mental or emotional disorders?	☐	☐
	If YES, did you submit your treating physician statement to the hospital for review?	☐	☐
20.	Have you ever incurred or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? (e.g. alcoholism, convulsive disorders)	☐	☐
	If YES, did you submit your treating physician statement to the hospital for review?	☐	☐

		YES	NO
21.	Have you ever been charged with, convicted or found guilty (even if adjudication withheld) of violating any federal, state law or municipal ordinance (other than traffic offenses or minor offenses involving a fine of $100.00 or less)? (Please explain on supplemental page.)	☐	☐
22.	Has your application for medical staff privileges at a hospital, other health care facility or managed care organization, ever been denied or restricted? (Please explain on supplemental page.)	☐	☐
23.	Have your medical staff privileges ever been revoked, suspended or restricted? (Please explain on supplemental page.)	☐	☐
24.	Have you ever received any of the following:		
	a) Any hospital disciplinary action due to professional reasons?	☐	☐
	b) Licensing board disciplinary or administrative proceeding due to impropriety or incompetence in a medical practice?	☐	☐
	c) Licensing board disciplinary or administrative proceeding due to prescribing, dispensing, or distributing pharmaceuticals?	☐	☐

		YES	NO
25.	Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered or subject to probationary terms (in any jurisdiction)?		
	a) Medical License	☐	☐
	b) DEA License	☐	☐

NOTE: If any of the questions are answered YES, a detailed explanation, in writing, MUST accompany application. Questions 18 through 20 require a letter from the attending physician or institution outlining the diagnosis, dates of treatment and current status. Questions 21 through 24 require a copy of all legal documents (e.g. Complaint, Stipulation, Final Order, Resolution).

EDUCATION

26. Medical School Name: City / State: Degree: From: To:

27. Post-graduate medical education *(list below in chronological order the type of training completed)*: From: To:

Residency/Specialty: _____

Name of Institution: _____

City: _____ State: _____

Fellowship/Sub-Specialty: _____ From: To:

Name of Institution: _____

City: _____ State: _____

SPECIALTY BOARD CERTIFICATIONS

		YES	NO
28.	Indicate if you are certified by the **American Board of Medical Specialties, Advisory Board for Osteopathic Specialists or American Podiatric Medical Association**	☐	☐
	If Yes, name of Board: _____ Date Certified: _____		
29.	If you are NOT certified:		
	a) Are you board eligible?	☐	☐
	If YES: Date of eligibility: _____ Anticipated exam date: _____		
	b) Have you been an applicant or candidate for over five years? If YES, please explain:	☐	☐
	_____		
	_____		
	c) Have you ever failed the written exam? If YES, please indicate the number of times: ____	☐	☐
	d) Have you ever failed the oral exam? If YES, please indicate the number of times: ____	☐	☐
	e) Have you ever been denied certification by a specialty board? If YES, please explain:	☐	☐
	_____		

PROFESSIONAL LIABILITY INSURANCE COVERAGE

30. List all professional liability insurance carried during the last ten years (use additional page if necessary):

Name of Carrier	Policy Effective	Policy Expiration	Specialty Covered	Type of Coverage (CM or Occ)

	YES	NO
31. Have you ever failed to maintain continuous professional liability insurance while rendering professional services? (If YES, please explain. Use additional page if necessary.)	☐	☐
32. Are you aware of any gaps in your Fund insurance with the Indiana PCF, and if yes, please provide exact dates and an explanation as to why?	☐	☐
33. Has there been a change in your specialty or rating classification during the time period states above? If YES, please explain. (Use additional page if necessary.)	☐	☐

CLASSIFICATION

34. Please check any of the following procedures you will perform:

- ☐ Abortions
  - ☐ First Trimester
  - ☐ Second Trimester
- ☐ Acupuncture
  - ☐ Therapeutic/Local Anesthesia
  - ☐ General Anesthetic
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arthroscopy
- ☐ Arteriography
- ☐ Assisting in major surgery
  - ☐ Own patients only
  - ☐ Own and other than own patients
- ☐ Blepharopigmentation
- ☐ Blepharoplasty – Brow Lifts
  - Cosmetic____% of practice
  - Reconstruction____% of practice
- ☐ Breast Implants
  - Cosmetic____% of practice
  - Reconstruction____% of practice
- ☐ Bronchoscopy
- ☐ Cataract Surgery
- ☐ Cryosurgery (other than external lesions)
- ☐ ERCP
- ☐ D & C
- ☐ Phenol Facial Peels
- ☐ Diagnostic Embolization
- ☐ General/Spinal/Caudal Anesthesia
  - ☐ Pulse Oximetry
  - ☐ End Tidal CO^2 Analyzer
  - ☐ End Tidal CO^2 Analyzer
- ☐ Hair Transplants
  - ☐ Scalp Excision/Transplantations
  - ☐ Plug Technique/Minigraph
- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Liposuction
- ☐ Lymphangiography
- ☐ Lithotripsy
- ☐ Major Gynecological Surgery
- ☐ Myelography
- ☐ Needle Biopsy
- ☐ Nerve blocks
  - ☐ Lumbar Epidural Steroid
  - ☐ Paraspinal
  - ☐ Sciatic
  - ☐ Facet
  - ☐ Paravertebral
  - ☐ Peripheral
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Trigger point injection
- ☐ Phlebography
- ☐ Pnuemoencephalography
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye
  - ☐ Non-Ionic Only
- ☐ Shock Therapy
- ☐ Sigmoidoscopy
  - ☐ Less than 60 cm
  - ☐ Greater than 60 cm
- ☐ Colonoscopy
- ☐ Polypectomy
- ☐Gastrointestinal Endoscopy
- ☐ Biopsy (Endoscopic)
- ☐ Peritoneoscopy
- ☐ Laser Therapy (Endoscopic)
- ☐ Pacemakers under General Anesthesia
- ☐ Silicone Injections
- ☐ Skin Flap/Grafts
  - Cosmetic___% of practice
  - Reconstruction___% of practice
- ☐ Swan-Ganz Catheterization
- ☐ Left Heart Catheterization
- ☐ Right Heart Catheterization (other than CVP Lines)
- ☐ Tubal Ligations
  - ☐ Vasectomies
  - ☐ On own patients
  - ☐ On other than own patients
- ☐ Weight Control Therapy/ Surgery ___% practice
  - ☐ Medication-Weight Control
  - ☐ Gastric Bubble
  - ☐ Gastric Stapling
  - ☐ Other Weight procedures
- ☐ Prenatal Practice
  - ☐ See patients during First and Second Trimester
  - ☐ See patients to Term but do not Perform Delivery
  - ☐ See patients to Term and Perform Delivery
- ☐ Normal Obstetrical Deliveries
  - How many per year?_____
- ☐ Cesarean Sections
  - How many per year?_____
- ☐ Home Deliveries
  - How many per year?_____
- ☐ Other Medical Techniques
  - _____
  - _____

35. Indicate the percentage of your surgical practice devoted to the following surgical activities:

___% Plastic(Reconstruction only)
___% Plastic(Cosmetic Enhancement)
___% Hand
___% Traumatic
___% Thoracic
___% Cardiac
___% Vascular
___% Obstetrics
___% Orthopedic (Including back)
___% Orthopedic (Not including back)
___% Other _____
_____

		YES	NO
36.	Do you attend or supervise deliveries in a non-hospital setting?	☐	☐
37.	Do you specialize in Neonatology?	☐	☐
38.	Do you perform any of the following:		
	a) Chelation Therapy for other than lead poisoning	☐	☐
	b) Gastric Bubble Treatment	☐	☐
	c) Second Trimester Abortions in a non-hospital setting	☐	☐

39. If you administer anesthesia, please provide the following information (check all that apply):

Monitoring Devices Used
- ☐ Pulse Oximeter
- ☐ CO2 – Oxygen analyzer
- ☐ Other: _____

Patient Profile
- ☐ Neonate
- ☐ Infant
- ☐ Child
- ☐ Adult

Location
- ☐ Hospital
- ☐ Office Surgical Suite
- ☐ Ambulatory Surgical Center
- ☐ Other: _____

40. Do you perform any procedure for which you do not have privileges? ☐ YES ☐ NO

If YES, please explain. (Use additional page if necessary.)

ENTITY AND ANCILLARY OPTIONS

ENTITY COVERAGE REQUESTED

41. Do you desire coverage for your Professional Entity? ☐ Yes ☐ No

42. Legal Name of Group to be _____

_____

dba: _____

Check One: _____ Partnership _____ Medical Corporation _____ Professional Association

_____ Solo Practitioner _____ Other (describe)

43. What type of coverage do you desire for your Professional Entity?

_____ Separate Limits **(This option is not available for Solo Practitioners)**
(There is an additional premium for this coverage)

_____ Shared Limits
(Solo Practitioners & Groups- there is no additional premium for this coverage).

44. Limits of Liability requested (limits indicated are per medical incident/annual aggregate): ☐ $250,000 / $750,000

45. Please list all the physician members of your Professional Association, Partnership, Corporation or Entity.
Please indicate whether Shareholder, Partner or Employee:

Physician Name	Shareholder	Partner	Employee
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐
6.	☐	☐	☐
7.	☐	☐	☐
8.	☐	☐	☐
9.	☐	☐	☐
10.	☐	☐	☐
11.	☐	☐	☐
12.	☐	☐	☐
13.	☐	☐	☐

ANCILLARY COVERAGE REQUESTED

If you employ highly trained Healthcare Ancillaries such as Advanced Registered Nurse Practitioners, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Physician Assistants, Optometrists, Psychologists, or Chiropractors (also known as Paramedicals or Physician Extenders), **these individuals must have coverage.** If any of the ancillaries you employ presently have their own individual coverage, please attach a Certificate of Insurance. However, if you wish to purchase coverage for these employees through our program, we can provide Share Limits Coverage::

- Shared limits: one set of limits is shared between the employer and ancillary

All other ancillaries will be covered on a Shared Limit basis either under the physician's limit or the entity's limit, depending upon whether Entity Coverage is purchased.

46. Please provide the names and license numbers for the highly trained Healthcare Personnel (as described above) that your practice employs, contracts and supervises. Coverage **must** be purchased for these individuals if they do not currently have individual coverage. Please indicate if you would like to purchase shared limits or separate limits. For those Healthcare Personnel who carry their own coverage, please indicate whether you wish to purchase vicarious liability coverage which would offer protection to you from claims resulting from the providing or failure to provide professional services by such personnel for whose acts you are legally responsible. **If any of these individuals have their own professional liability insurance, attach a Certificate of Insurance.**

Name:	License #	Type (Indicate if ARNP, CNM, CRNA, PA, OD, PhD, or DC only. *Other ancillaries such as RN's and LPN's etc. do not need to be listed.)*	**Coverage Requested through FWMAC:**	**Has Own Coverage – Vicarious Liability Requested?**	
			Shared Limits Basis	Yes	No
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐
11.			☐	☐	☐
12.			☐	☐	☐
13.			☐	☐	☐
14.			☐	☐	☐
15.			☐	☐	☐
16.			☐	☐	☐

ANCILLARY CLAIM INFORMATION

47. Regarding the ancillaries named above requesting either shared or separate limits through our program, has any claim or suit for alleged malpractice been brought against any of them? ** If YES, please have the attached Claim Information Form completed by the ancillary for EACH CLAIM.*	☐ Yes * ☐ No

REMEMBER!!

If any of these individuals have their own professional liability insurance, attach a Certificate of Insurance, otherwise, we will automatically charge a premium for them on a shared limits basis.

CLAIM INFORMATION

A "Potential Claim or Suit" includes, without limitation, instances where you have received an oral or written communication from an individual or his legal representative demanding explanations or satisfaction or threatening legal action. It also includes a request by a patient or the patient's legal representative for copies of medical records under circumstances reasonably indicative of a possible claim or suit.

		YES	NO
48.	Has any claim or suit for alleged malpractice been brought against you or your professional association, partnership or corporation?	☐	☐
	If YES, please indicate how many times: _____		
49.	Other than above, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?	☐	☐
	a) A request for records from a patient and/or attorney related to an adverse outcome?	☐	☐
	b) A letter from an attorney regarding your medical treatment of a patient?	☐	☐
	c) Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	☐	☐
	d) Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis?	☐	☐
	e) Any other circumstances that might reasonably lead to a claim or suit?	☐	☐
50.	Other than above, have all circumstances that might reasonably lead to an incident, claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior Professional Liability carrier?:	☐	☐
	If YES, please indicate how many times: _____ **Please attach documentation of all such reports.**		
	If NO, please explain: _____		
51.	If you practice in a partnership, multi-member professional association or corporation - Are you aware of any circumstances in which members of your group have been named in a suit but you or any other members of your group also treated the patient but were not named in the suit?	☐	☐
52.	If you are NOT AN OBSTETRICIAN, have you ever been involved in an obstetrical case regardless of whether case is open, closed or if a payment was made or not made?	☐	☐
53.	Have you ever been involved in a case where it has been proven that alteration of medical records has occurred, regardless of whether case is closed or if a payment was made or not made?	☐	☐

I hereby declare that the above information is complete and true to the best of my knowledge and belief.

_____

PRINT OR TYPE NAME OF OFFICE MANAGER

X _____ _____

Signature of Office Manager Date of Signature

(A Separate Incident/Claim Information Form MUST be completed for each incident, potential claim, claim or suit.)

INCIDENT/CLAIM INFORMATION FORM (Past or Pending)

If you answered YES to Questions 48-53, you must complete this form with respect to any incident, potential claim, claim or suit against you. Photocopy this form if you have more than one incident, potential claim, claim or suit to report. (Attach all supplemental information necessary.)

1. Physician Name / Healthcare Ancillary Name:

2. a) Patient/Claimant name:	b) Age	c) Gender
3. a) Physical condition and diagnosis at time of incident:	b) Date of first consultation:	
4. a) Date of incident or occurrence from which claim resulted:	b) Date claim was filed:	
5. a) Description of treatment rendered:	b) Date of treatment:	

6. Allegations made against you (state injury or damages alleged):

_____

_____

_____

7. Subsequent condition or health of patient:

8. Was this claim reported to your insurance carrier (if YES, list name of carrier and policy number): ☐ Yes ☐ NO
Carrier Name: Policy Number:

9. Present status or disposition of claim including amount of settlement or judgement:

☐ Open ☐ Closed Amount Paid on Your Behalf: _____
Date Closed_____

I hereby authorize release to Aon Risk Services and its agents for information from my insurance carriers, their adjusting firms, and attorney concerning past or present claim matters in which I am involved.

X _____ _____

Signature of Applicant Date of Signature

(A photostatic copy of this authorization shall be considered as effective and as valid as the original. Each incident/claim information form must have physician's original signature.)

(A Separate Incident/Claim Information Form MUST be completed for each incident, potential claim, claim or suit.)

INCIDENT/CLAIM INFORMATION FORM (Past or Pending)

If you answered YES to Questions 48-53, you must complete this form with respect to any incident, potential claim, claim or suit against you. Photocopy this form if you have more than one incident, potential claim, claim or suit to report. (Attach all supplemental information necessary.)

1. Physician Name / Healthcare Ancillary Name:

2. a) Patient/Claimant name:	b) Age	c) Gender
3. a) Physical condition and diagnosis at time of incident:	b) Date of first consultation:	
4. a) Date of incident or occurrence from which claim resulted:	b) Date claim was filed:	
5. a) Description of treatment rendered:	b) Date of treatment:	

6. Allegations made against you (state injury or damages alleged):

_____

_____

_____

7. Subsequent condition or health of patient:

8. Was this claim reported to your insurance carrier (if YES, list name of carrier and policy number): ☐ Yes ☐ NO
Carrier Name: Policy Number:

9. Present status or disposition of claim including amount of settlement or judgement:

☐ Open ☐ Closed Amount Paid on Your Behalf: _____
Date Closed_____

I hereby authorize release to Aon Risk Services and its agents for information from my insurance carriers, their adjusting firms, and attorney concerning past or present claim matters in which I am involved.

X _____ _____

Signature of Applicant Date of Signature

(A photostatic copy of this authorization shall be considered as effective and as valid as the original. Each incident/claim information form must have physician's original signature.)

ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer, _____, both the right to cancel my policy and the return of any
(insert employer name)

unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

Initial Here ☐

PLEASE READ AND SIGN

I certify that any and all answers given above represent full and true disclosure of the facts sought by Aon Risk Services, Inc. I understand and agree that any misrepresentation, omission, misstatement of fact in this application that is material to the risk shall be grounds for rescission of all coverage granted pursuant to this application.

I understand that the information given is confidential and will be used only for medical professional liability evaluation.

I understand that any and all answers to the above questions are subject to verification, and that all required documentation must be furnished, that significant discrepancies will require clarification on my part before the application can be considered.

I understand that I am applying for individual Occurrence coverage or Claims-made coverage **without Prior Acts.**

.

I hereby certify that following careful review of my professional activities, including patient records, I have reported to my present carrier all claims, suits, or potential claims or suits, as defined in the application, in which I am involved or in which I may become involved, arising out of events that took place during the period of my coverage with my present carrier. I understand that I will not have coverage for claims or suits, or potential claims or suits, which were or should have been reported to my present carrier.

I understand that disapproval of my application in no way represents a reflection upon me personally or upon my qualifications as a practitioner of medicine. I further understand and agree that if my application is not approved, the reason(s) for its disapproval will be kept in strict confidence. I hereby agree to release from liability for slander, libel, defamation of character, or any and all other causes of action, employees of Aon Risk Services, Inc. and any of its directors, agents, designees, committees, or committee members.

I AGREE TO IMMEDIATELY NOTIFY AON RISK SERVICES, INC. IN WRITING, IF THERE IS ANY CHANGE IN ANY ANSWER GIVEN IN MY APPLICATION INCLUDING ANY CHANGE IN MY PROFESSIONAL STATUS, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY OTHER PHYSICIAN, FIRM OR PROFESSIONAL ASSOCIATION, AND I UNDERSTAND AND AGREE THAT SUCH CHANGES ARE MATERIAL TO THE RISKS COVERED BY THE RISK RETENTION GROUP I AM APPLYING FOR.

NOTICE TO APPLICANTS:
Any person who knowingly and with intent to injure, defraud, or deceive an insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony in the third degree.

I hereby authorize release of any information requested by Aon Risk Services, Inc. in connection with the underwriting of my application for professional liability insurance coverage. I consent to the FWMAC underwriting committee accessing and reviewing any information contained in the credentialing files for any Hospitals at which I maintain staff privileges. A photostatic copy of this authorization shall be considered as effective and as valid as the original.

_____
PRINT OR TYPE NAME OF APPLICANT

X _____ _____
Signature of Applicant Date of Signature

SUPPLEMENTAL PAGE