



**PROFESSIONAL UNDERWRITERS
LIABILITY INSURANCE COMPANY**

A TDC Company

1888 Century Park East, Suite 850 Los Angeles, CA 90067-1737

NEUROSURGEON'S PROFESSIONAL LIABILITY POLICY NEW BUSINESS APPLICATION

Instructions: All questions must be answered. Please type or print clearly. No coverage is in place until application is approved and premium paid. All requested explanations and documents must be attached including: current declarations page, CV & currently valued loss runs.

NOTICE
This is an application for a CLAIMS-MADE POLICY

1. (a) Applicant's Full Name: _____ Degree/Title: _____
 Other Name Used: _____ Birth Date: _____

(b) Social Security #: _____ (c) Federal DEA #: _____ Male Female

(d) Home Address: _____ Phone: (____) _____
 Number Street City County State Zip

(e) Principal Office: _____ Phone: (____) _____
 Number Street City County State Zip Fax: (____) _____

(f) Other Office Address(es): _____ Phone: (____) _____
 (if any) Number Street City County State Zip Email: _____

2. Specify States where you are licensed:

| | | |
|--|--|--|
| _____ (License #) _____ (State of Licensure) _____ (Field) | _____ (License #) _____ (State of Licensure) _____ (Field) | _____ (License #) _____ (State of Licensure) _____ (Field) |
|--|--|--|

3. (a) Medical Specialty: _____ (b) Sub-Specialty: _____ % of Practice: _____

4. (a) What is your average weekly patient load? _____ (b) How many surgical procedures do you perform each week? _____

5. If my application is approved, make coverage effective on _____, if possible, otherwise on any other date set by the Company.

6. (a) Type of Practice (check all boxes that apply):

| | | |
|--|---|--|
| 1. <input type="checkbox"/> Individual (solo) Unincorporated | 4. <input type="checkbox"/> Member of Multi-person Corporation or Association | 7. <input type="checkbox"/> Other (Describe) |
| 2. <input type="checkbox"/> Individual (solo) Corporation | 5. <input type="checkbox"/> Employee of: _____ | |
| 3. <input type="checkbox"/> Partnership | 6. <input type="checkbox"/> Independent Contractor of: _____ | |

(b) List Federal Taxpayer Identification Number(s) and name(s) of corporate entity(ies):

| | |
|-------------------|--|
| _____ Entity Name | _____ Federal Taxpayer Identification Number |
| _____ Entity Name | _____ Federal Taxpayer Identification Number |

(c) Please list name(s) of ALL other partners, stockholders, associates, independent contractors and employed physicians. **(Indicate status of each and provide proof of coverage for each).**

| | |
|------------------------------|------------------------------|
| 1. _____ Name Current Limits | 4. _____ Name Current Limits |
| 2. _____ Name Current Limits | 5. _____ Name Current Limits |
| 3. _____ Name Current Limits | 6. _____ Name Current Limits |

7. (a) Are you American Board Certified in your Specialty? YES NO Date(s) Certified: _____
 (b) Are you American Board Certified in your Sub-Specialty? YES NO Date(s) Certified: _____
 (c) Name(s) of Specialty Board(s): _____

(d) If you are a foreign medical graduate, are you certified by the Educational Commission for Foreign Medical Graduates? YES NO
 (e) Have you ever failed any Board Certification testing? YES NO
 If YES, please explain: _____

ATTESTATION QUESTIONS

- | | YES | NO |
|--|--------------------------|--------------------------|
| 8. If the answer to any of the following is YES, please give full details (including dates) on a separate sheet of paper: | | |
| (a) Have you <u>ever</u> had professional liability insurance declined, canceled, issued on special terms or non-renewed? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Have you <u>ever</u> been investigated or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? (If YES, provide copies of all Accusations, Decisions, Consent Orders, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Has or is your license to practice medicine or your permit to prescribe or dispense drugs <u>ever</u> been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Have you <u>ever</u> had privileges at any hospital or other institution denied, reduced, revoked, restricted, or suspended? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Are you currently or have you <u>ever</u> been evaluated, treated or hospitalized for alcohol or drug abuse or a mental or emotional disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Have you <u>ever</u> been convicted of, or are you under indictment for, a felony? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Has your membership in any professional society or association <u>ever</u> been refused, censured, suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Do you currently have or have you <u>ever</u> had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Are you currently or have you <u>ever</u> used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Has any physician, patient or insurance plan <u>ever</u> filed a complaint against you with any Medical Association/ Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau? | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Have you <u>ever</u> been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)? | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Have you <u>ever</u> been involved in a malpractice claim, suit or medical incident, either directly or indirectly, or are you presently involved in malpractice litigation? (If YES, please complete a Claims Information Form for each.) | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Are you aware of any facts, circumstances, medical incidents, records requests or letters of intent that may give rise to a claim or suit? (If YES, please complete a Claims Information Form for each, attached to this Application). | <input type="checkbox"/> | <input type="checkbox"/> |

TRAINING & INSURANCE HISTORY

- | | | | | | |
|--|----------|-------|---------|----------------------|----------------------|
| 9. (a) Medical Degree from (school): _____ | | | | Dates: _____ | |
| | City | State | Country | mm/dd/yy to mm/dd/yy | |
| (b) Internship: _____ | | | | Dates: _____ | |
| | Hospital | City | State | Country | mm/dd/yy to mm/dd/yy |
| (c) Residency: _____ | | | | Dates: _____ | |
| | Hospital | City | State | Country | mm/dd/yy to mm/dd/yy |
| (d) Type of Residency: _____ | | | | | |
| (e) Residency: _____ | | | | Dates: _____ | |
| | Hospital | City | State | Country | mm/dd/yy to mm/dd/yy |
| (f) Type of Residency: _____ | | | | | |
| (g) Fellowship Training: _____ | | | | Dates: _____ | |
| | Hospital | City | State | Country | mm/dd/yy to mm/dd/yy |
| (h) Type of Fellowship: _____ | | | | | |

10. List any additional medical specialty training:

| <u>Location</u> | <u>Type</u> | <u>Dates</u> |
|-----------------|-------------|--------------|
| _____ | | |
| _____ | | |
| _____ | | |

11. List malpractice coverage for the past 10 years, beginning with your current or most recent carrier:

| Name of Insurer | Dates Covered From – To (MM/DD/YY) | Limits of Liability | Retro-active Date | Coverage Type (Occurrence or Claims-Made) | Premium | Was Tail Coverage Purchased? | # of Pending Claims | # of Closed Claims | Total # of Claims |
|-----------------|------------------------------------|---------------------|-------------------|---|---------|------------------------------|---------------------|--------------------|-------------------|
| A | | | | | | | | | |
| B | | | | | | | | | |
| C | | | | | | | | | |
| D | | | | | | | | | |

- PLEASE ATTACH A COPY OF YOUR MOST RECENT DECLARATION'S PAGE AND POLICY.
- PLEASE FILL OUT A CLAIM INFORMATION FORM FOR EACH SUIT, CLAIM, LETTER OF INTENT AND INCIDENT, OPEN OR CLOSED, AND SUBMIT ANY ADDITIONAL INFORMATION RELATIVE TO THESE CLAIMS.

- (a) Do you intend to purchase a reporting endorsement (a.k.a. Tail Coverage) from your current insurer? YES NO
- (b) If answer to (a) is NO, do you wish to obtain Prior Acts Coverage from us? **NOTE: The offering of Prior Acts Coverage is subject to Underwriter approval.** YES NO
- (c) If answer to (b) is YES, please attach a copy of your present insurance policy, with all endorsements, and complete the following:

Applicant is/is not (**circle one**) as of this date aware of any Claims, Suits, Letters of Intent, Records Requests or Incidents that have not been reported to his/her (**circle one**) present or prior insurer(s). Please Initial: _____

NOTE: If you do not purchase Prior Acts Coverage from us you will not have any coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.

PRACTICE QUESTIONS

12. (a) Do you perform surgery in your office? YES NO (c) Is general anesthesia administered:
- (b) Do you perform surgery in any other non-hospital facility? YES NO 1. By you? YES NO
2. By others? YES NO

If answer to (b) is YES, list and describe facilities where surgery is performed: _____

- (d) List the surgical procedures you perform in your office or other non-hospital facility:

13. (a) Do you treat or review the treatment of prison inmates? YES NO % of practice: _____

If YES, please explain (include facility names): _____

- (b) Is insurance coverage provided for this work by the above facility? YES NO

14. (a) Do you practice as a professional sports team physician? YES NO % of practice: _____

- (b) Do you practice as an amateur sports team physician? YES NO % of practice: _____

If YES, please explain (include duties, team names and type of sport): _____

15. Do you perform medical legal evaluations? YES NO % of practice: _____

If YES, with whom? _____

16. Do you treat or consult on patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands?

YES NO If YES, where? _____ % of practice: _____

17. Do you advertise your medical practice? YES NO If YES, what states: _____
 If YES, list medium(s) and frequency for each: _____
 If YES, provide copies of advertisements that you are currently using or have placed in periodicals, yellow pages, on flyers, handouts, etc. Please provide a copy of the script if you are using voice or film media.

18. Do you have any Internet Web-Site addresses? YES NO If YES, specify addresses: _____

19. Do you perform consultations outside the state of your primary office address, including but not limited to, the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (tele-medicine or internet medicine) or do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address?
 YES NO If YES, what percentage of your total practice: _____
 If YES, identify all states in which such patients reside: _____

20. Do you treat patients who reside outside the state of your primary office address? YES NO
 If YES, what percentage of your practice: _____

21. List all locations where you have practiced in the last 10 years:

| | <u>Group Name</u> | <u>Street</u> | <u>City</u> | <u>County</u> | <u>State</u> | <u>During Years</u> |
|-----|-------------------|---------------|-------------|---------------|--------------|---------------------|
| (a) | _____ | | | | | |
| (b) | _____ | | | | | |
| (c) | _____ | | | | | |
| (d) | _____ | | | | | |

22. Do you (YES NO) or your professional entity (YES NO) employ or contract for the services of any health care personnel? If YES, provide number of each and indicate if coverage (shared limits) is desired for each. **NOTE: If employed by an entity, coverage may not be available.**

| | <u># Employed</u> | <u>Is Coverage Desired?</u> | <u># of Independent Contractors</u> | <u>Are they Insured?</u> |
|------------------------------|-------------------|--|-------------------------------------|--|
| (a) Nurses | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (b) Technicians | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (c) Psychologists | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (d) Physical Therapists | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (e) Physician's Assistants** | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (f) Nurse Practitioners** | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (g) CRNA's** | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (h) Nurse Midwives** | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (i) Other: _____ | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (j) Other: _____ | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> | _____ | YES <input type="checkbox"/> NO <input type="checkbox"/> |

****If YES, please submit a written explanation of practice and procedures performed, along with certificate of course completion and license number. Provide proof of insurance if insured elsewhere. If coverage is desired, please complete a Professional Underwriters Liability Insurance Company Allied Personnel Application for each.**

23. Are you associated in any capacity with, or do you own, any of the following:

(a) Any health care facility having bed and board accommodations? YES NO

(b) Any surgicenter, clinic, urgent care center, foundation, blood bank, laboratory, abortion clinic or birthing center? YES NO

If answer to (a) or (b) is YES, are you:

1. Owner (whole or part) 3. Executive Officer 5. Director of Ancillary Services Dept. 7. Administrator
 2. Committee Member 4. Medical Director 6. Other (explain) _____

(c) Any other medically related business enterprise? YES NO

If answer to (c) is YES, please explain: _____

24. Are you a physician with teaching responsibilities? YES NO

If YES, please explain: _____

If YES, is insurance coverage provided by this institution or facility? YES NO

25. List all facilities (i.e. hospitals, surgicenters, etc) where you are currently on staff and show percentage of work in each facility:

| | <u>Facility Name</u> | <u>City</u> | <u>County</u> | <u>State</u> | <u>Type of Privileges</u> | <u>Percentage of Work</u> |
|-----|----------------------|-------------|---------------|--------------|---------------------------|---------------------------|
| (a) | _____ | _____ | _____ | _____ | _____ | _____ |
| (b) | _____ | _____ | _____ | _____ | _____ | _____ |
| (c) | _____ | _____ | _____ | _____ | _____ | _____ |
| (d) | _____ | _____ | _____ | _____ | _____ | _____ |

26. (a) Are you a "Hospitalist"? YES NO

(b) Do you work in any Emergency Room? YES NO

If YES to (b), is it required solely to maintain staff privileges? YES NO

(c) Do you provide any Locum Tenens services? YES NO

(d) Do you "moonlight" at any other facilities? YES NO

(e) Do you provide any services at a hotel, spa or health club? YES NO

If YES to any of the above, please explain: _____

27. Do you treat patients in any nursing home, skilled nursing facility or assisted living center? YES NO

If YES, % of practice: _____ If YES, do you treat other than your own patients? YES NO

28. Are you a medical director of any nursing home, skilled nursing facility or assisted living center? YES NO

If YES, provide evidence of coverage for each facility.

29. Do you use experimental devices or drugs or do you perform experimental procedures or therapy in treatment or surgery or are you a principal investigator for any clinical trial?

YES NO

If YES, do you follow FDA approved protocols? YES NO If YES, describe: _____

30. Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? YES NO

If YES, have you implemented procedures to comply with the HIPAA Privacy Rule? YES NO

31. How many days do you work per week? _____ Hours per day? _____

32. What % of your patient's are: (a) over age 65? _____ (b) Age 18 or younger? _____

33. Has your practice (e.g. specialty, procedures or practice environment) changed in the last five years? YES NO

If YES, please explain: _____

EXPLANATIONS, REMARKS & NOTES: _____

34. Please answer "YES" or "NO" as to whether you perform or desire to perform the following procedures. Additionally, please include the estimated number of times you have performed each procedure in the past 12 months as well as how many times you anticipate performing each procedure in the next 12 months.

| | As Surgeon | | | | As Assistant | | | |
|--|--------------------------|--------------------------|-----------|-----------|--------------------------|--------------------------|-----------|-----------|
| | | | # in past | # in next | | | # in past | # in next |
| | NO | YES | 12 Mo.'s | 12 Mo.'s | NO | YES | 12 Mo.'s | 12 Mo.'s |
| Acoustic Tumor Removal | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Aneurysm Clipping | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Arteriovenous Malformation Removal | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Anterior Cervical Discectomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Brachial Plexus Exploration | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Brain Tumor (Intrinsic) Removal | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Carotid Endarterectomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Carpal Tunnel Release | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Cervical Discectomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Cervical Laminectomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Cervical Stabilization Posterior | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Craniofacial Reconstruction | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Craniosynostectomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Craniotomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Deep Brain Stimulator | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Epidural Hematoma Evacuation | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Foraminotomy - Cervical | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Foraminotomy – Lumbar | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Gamma Knife | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Glioma Resection | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Joint Implants | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Laminectomy - Cervical | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Laminectomy – Lumbar | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Lumbar Fusion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Lumbar Discectomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Lumbar Puncture | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Lumboperitoneal Shunt Insertion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Meningioma Removal | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Microvascular Decompression | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Morphine Pump Insertion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Myelomeningocele Closure | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Neck Exposure | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Neuro Implant Surgery for Pain | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Pallidotomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Pedicle Screws - Insertion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Pedicle Screws - Removal | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Posterior Fossa Decompression | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Prolotherapy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Prolotherapy – using Phenol | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Scoliosis Surgery | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Spinal Fusion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Stereotactic neurosurgery | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Subdural Hematoma Evacuation – Acute | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Subdural Hematoma Evacuation – Chronic | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Sural Nerve Biopsy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Temporal Lobectomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Transsphenoidal Craniotomy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Vagal Nerve Stimulator Insertion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Ventriculoperitoneal Shunt Insertion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Ventriculoperitoneal Shunt Revision | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Vertebroplasty | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |

35. What is your Subspecialty?

| | As Surgeon | | As Assistant | |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | NO | YES | NO | YES |
| (a) Trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Cerebrovascular | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Stereotactic & Functional | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Spine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Pediatric | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Peripheral Nerves | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Tumors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Endovascular | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Skull Base | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Other (please specify) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | As Surgeon | | As Assistant | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | NO | YES | NO | YES |
| 36. Indicate below any other procedures that you perform which are commonly considered to be surgery: | | | | |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

37. If you perform spinal surgery, describe special training or experience: _____

NO KNOWN CLAIMS DECLARATION

I declare that I am not aware of, nor do I, or any agent, employee, representative, or any other person(s) serving or acting on my behalf have any knowledge of any claim, notice of claim, records request, letter of intent, incident, any unreported conduct, or any circumstance or occurrence which could reasonably be expected to result in a claim against me subsequent to the date of my signature below that I have not already reported to my previous professional liability carrier and which I have not disclosed on my application to Professional Underwriters Liability Insurance Company.

I have reported all claims, and all facts or circumstances that could give rise to a claim to appropriate prior carrier(s) and understand that all such known claims or potential claims will not be covered by this insurance. I also understand that this insurance does not apply to any of the following:

1. Any incident or claim for which I have received notice of a claim.
2. Any incident or claim for which a legal action has been filed against my employees or me.
3. Any incident or claim upon which any companies previously insuring me have previously established a claim file.
4. Any incident or claim arising out of any fact, circumstance, or situation indicating the possibility of a claim which was known to me as of the effective date of insurance for which I am applying.

Signature: **X** _____

Date: _____ / _____ / _____

Print Name

WARRANTY & RELEASE

I do hereby warrant the truth of all statements and answers mentioned herein, and that I have not withheld any information which may influence or would influence the judgment of the Company in considering this application for professional liability insurance.

I understand that if the information in this application materially changes between the date of this application and the policy effective date, I will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

I understand and agree that erroneous and/or material misrepresentations or omissions will cause immediate rescission of my insurance coverage.

I understand and agree that the Company will not provide defense or indemnity coverage for any claims, civil lawsuits, arbitration, legal or administrative proceedings, incidents, accidents, or events in which damages or liability is assumed or imposed, or sought to be imposed, upon an insured under a written or oral agreement, specifically including a "hold harmless" indemnification or similar agreement, where the damages or liability assumed by, imposed or sought to be imposed are greater than that which would exist in the absence of such an agreement.

This application form, duly completed, together with any supplementary information, **must** be signed and dated in ink by the applicant. Signature of the form does not bind the applicant or the Company to issue coverage.

Signature: **X** _____

Date: _____ / _____ / _____

I understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, preceptorship, residency program, insurance company, underwriter and insurance agent/broker to furnish any information concerning me or my medical practice which the company or its representative may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction, together with the agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even if the information is wrong.

Signature: **X** _____

Date: _____ / _____ / _____

CLAIMS INFORMATION FORM

CLAIM INFORMATION - Please type or print clearly

1. Name of Patient: _____ 2. Age: _____ 3. Sex: _____

4. Your relationship to patient: _____

5. Allegation(s) (as stated by patient/plaintiff): _____

6. Date of Incident: _____ 7. Date Reported to Carrier: _____ 8. Location: _____

9. Insurance Carrier(s): _____

10. Other Defendants: _____

11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES NO

12. Present Status: _____ Incident Only _____ Pending Suit _____ Closed

Date Closed: _____ Amount Paid: _____ Settlement or Judgment (circle one)

13. Condition and diagnosis at time of treatment: _____

14. Dates and description of treatment rendered: _____

15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): _____

16. Defense Counsel: _____

17. Plaintiff's Counsel: _____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X** _____

Date: _____ / _____ / _____

CLAIMS INFORMATION FORM
(Please make additional copies if needed)

CLAIM INFORMATION - Please type or print clearly

1. Name of Patient: _____ 2. Age: _____ 3. Sex: _____

4. Your relationship to patient: _____

5. Allegation(s) (as stated by patient/plaintiff): _____

6. Date of Incident: _____ 7. Date Reported to Carrier: _____ 8. Location: _____

9. Insurance Carrier(s): _____

10. Other Defendants: _____

11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES NO

12. Present Status: _____ Incident Only _____ Pending Suit _____ Closed

Date Closed: _____ Amount Paid: _____ Settlement or Judgment (circle one)

13. Condition and diagnosis at time of treatment: _____

14. Dates and description of treatment rendered: _____

15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): _____

16. Defense Counsel: _____

17. Plaintiff's Counsel: _____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X** _____

Date: _____ / _____ / _____

NOTICE:

The underwriter is authorized to make any inquiry in connection with this application. The underwriter's acceptance of this application or the making of any subsequent inquiry does not bind the applicant or the underwriter to complete the insurance or issue a policy.

If the information in this application materially changes between the date of this application and the policy effective date, the applicant will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia 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.

Florida Applicants: 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.

Kentucky Applicants: 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.

Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

Maryland Applicants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri Applicants: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

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.

New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines civil and criminal penalties.

Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Applicants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania Applicants: 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 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.

Rhode Island Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Applicants: 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.

Virginia Applicants: 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 and civil damages.

West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.