



**CNA HEALTHPRO
PHYSICIANS' PROTECTION PROGRAM**

MEDICAL PRACTITIONER'S APPLICATION

THIS APPLICATION IS FOR A CLAIMS-MADE POLICY WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST INSURED DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

Carefully read this page and the questions posed in this application. In order for you to be considered for coverage, this application must be completed in full and submitted along with required attachments and/or supplementary information requested throughout the application. ***In order to expedite the underwriting process, please write legibly and ensure that all questions have been fully answered.*** Additional information may be required upon review of the application. If the application does not provide you with sufficient space to properly respond to a question, please write "see attached" and respond via separate attachment. Please be sure to sign and date the attachment.

➤ **The following required attachments must be submitted along with the fully completed application.**

- Copy of current Insurance Policy declarations page.
- Copy of the Extended Reporting Endorsement from your current/past carrier(s) if your current coverage is claims-made and you are **not** applying for prior acts coverage (aka retroactive or nose coverage).
- Up-to-date Curriculum Vitae/Resume.
- Copies of all current advertising materials such as Brochures, Yellow Pages, Newspaper, and/or Magazine advertisements. Also include copies of scripts for voice and/or film media.
- Formal, up-to-date loss runs from all prior insurance companies for the past 5 years.
- A **CLAIM / INCIDENT / SUIT SUPPLEMENT FORM** must be completed for each claim, incident and/or suit you have ever been involved either directly or indirectly. You must also complete this form for any precautionary report (aka incident report) you have submitted to your present or past professional liability insurance carrier(s) in the past 5 years.
- Copy of your business letterhead.

➤ **Please contact your underwriter at 1-800-341-3684 if you have any questions concerning this application or the coverage for which this application applies.**

NOTE:

This is an application for insurance, not an insurance binder. Your application is subject to underwriting review and approval by the company. The effective date, prior acts date (aka retroactive date or nose coverage), and additional classification and/or rating aspects of this application are also subject to approval by the company. In no event can the requested coverage effective date be prior to the date this application is received by us. No offer of coverage exists unless and until this application is accepted/approved by the company **and** you have received written notification of said acceptance.

COMPANY/AGENCY USE ONLY

Territory	Dec ISO	PLD code	Policy number	Group	Producer number
Step	Rate ISO	Rate class	Account number	Producer's name	



I PERSONAL/PROFESSIONAL DATA

Name (last, first, middle)	Designation <input type="checkbox"/> MD <input type="checkbox"/> DO
----------------------------	--

Clinic name/Employer

Maiden Name (if applicable)	Date of birth (MM/DD/YY)
-----------------------------	--------------------------

Have you ever practiced under a name other than as it appears on your medical license? No Yes
 If yes, under what name(s) have you practiced and attach a copy of the applicable legal documents:

Primary practice address	City	State	Zip Code	County
--------------------------	------	-------	----------	--------

Residence address	City	State	Zip Code	County
-------------------	------	-------	----------	--------

Telephone – office	Fax number	Telephone – residence
--------------------	------------	-----------------------

Number of years at current office location	If less than three years, list previous locations and dates
--	---

Tax I.D. number	Social Security number
-----------------	------------------------

Additional practice locations	Email Address
-------------------------------	---------------

Desired policy dates

Effective date: _____
 Prior Acts date: _____

Desired coverages/limits

Professional liability: \$ _____ each claim
 \$ _____ aggregate

1. If you are currently insured by a claims-made policy:

- A. Are you obtaining Extended Reporting (“tail”) coverage from your current insurance company? No Yes
 - B. Is Prior Acts coverage being requested? No Yes
- If Yes, show Prior Acts effective date: _____

Note: To prevent possible gaps in your claims-made coverage, either Extended Reporting or Prior Acts coverage must be purchased.

2. Have you **ever** practiced without insurance or had a claims-made policy lapse without purchasing the Extended Reporting Period (aka “Tail”) Endorsement? No Yes

IF YES, please explain circumstances (i.e. “why”) and note date(s):

II MEDICAL TRAINING AND HISTORY

Please answer all questions completely. If a question does not apply to you, mark "N/A" or "0."
Do not leave any questions unanswered. If space is inadequate, use the Comments section or attach a separate sheet.

3. Medical specialty: _____ Percentage of practice: _____ %

Sub-specialty: _____ Percentage of practice: _____ %

A. Do you limit your practice to the above Specialty and/or Sub-specialty? No Yes

IF NO, please explain: _____

B. Will you or have you provided professional services outside of the United States? No Yes

IF YES, please explain (provide dates professional services were provided outside of the US and what procedures were performed):

C. Have you added or discontinued procedures which are considered to be outside of, or not usual to the above practice specialty, or are experimental in nature? No Yes

IF YES, please list procedures/services and note dates of change(s):

D. Have you changed your medical specialty? No Yes

IF YES, please provide complete details and note dates of change(s):

4. Medical education

A. Medical school: Institution	State	From	To	Completed?
				<input type="checkbox"/> No <input type="checkbox"/> Yes

B. Internship: Institution	State	From	To	Completed?
				<input type="checkbox"/> No <input type="checkbox"/> Yes

C. Residency: Institution	Specialty	State	From	To	Completed?
					<input type="checkbox"/> No <input type="checkbox"/> Yes

D. Residency: Institution	Specialty	State	From	To	Completed?
					<input type="checkbox"/> No <input type="checkbox"/> Yes

E. Fellowship: Institution	Specialty	State	From	To	Completed?
					<input type="checkbox"/> No <input type="checkbox"/> Yes

5. If you are a graduate of a foreign medical school:
 • are you certified by the Education Council for Foreign Medical Graduates? No Yes Date completed: _____
 • have you passed the CFMG? No Yes

6. Number of hours continuing education completed within the past two years: _____ hrs.

II MEDICAL TRAINING AND HISTORY (continued)

7. Medical license information

Please list all of your medical licenses including all active and inactive licenses:

State	License number	Expiration date	Status

8. In regard to your Medical License:

- a. Has any State/Medical Board ever refused you a medical license? No Yes
- b. Has any State/Medical Board ever restricted, suspended or revoked your medical license? No Yes
- c. Has any State/Medical Board ever imposed a fine or any other obligation? No Yes
- d. Has any State/Medical Board ever issued a letter of guidance? No Yes
- e. Have you ever voluntarily surrendered a medical license? No Yes
- f. Has any State/Medical Board ever placed you on probation or restricted your practice? No Yes
- g. Is your medical license currently under investigation for any reason? No Yes
- h. **IF YES** to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents:

9. Narcotics/DEA license number: _____ Status: _____

10. **Has your Narcotics/DEA license** ever been surrendered/refused/suspended/revoked, voluntarily or otherwise? No Yes
IF YES, describe circumstances, outcome, dates, and attach copies of any relevant documents:

11. ABMS (American Board of Medical Specialties) and/or AOA (American Osteopathic Association) Certification Information

a. Board certification information

Name of board: _____ Certified Qualified

Name of board: _____ Certified Qualified

Name of board: _____ Certified Qualified

b. How many times have you taken the exam(s) for certification? Orals: _____ Written: _____

c. If you are **not ABMS** or **AOA** certified, do you intend to pursue certification? Please check appropriate box below and respond accordingly:

- N/A** ⇔ **IF N/A**, (i.e. you are already certified) please skip the rest of this question.
- YES** ⇔ **IF YES**, please use space below to outline your plans for pursuing certification.
- NO** ⇔ **IF NO**, please use space below to explain why you do not intend to pursue certification and/or why you are not certified. If additional space is needed, please write "see attached" and respond via separate attachment.

d. Has your board certification or membership in any medical association/society ever been refused, suspended, revoked or voluntarily surrendered? If yes, please respond via separate attachment. No Yes

II MEDICAL TRAINING AND HISTORY (continued)

12. Date and location you first began practicing: _____
Date City, State

13. **List locations where you have practiced since** completion of Residency and/or Fellowship program(s) to date and explain any gaps in your practice history. **If provided in Curriculum Vitae or Resume, please indicate that below.**

Type of practice or position (e.g., group or private practice, hospital employee, medical director, independent contractor, etc.)	Physical street address	City	State	Dates (Month/Year)	
				Start	End

14. **Have you ever** been evaluated, treated or recommended for treatment of alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? No Yes
IF YES, describe circumstances, outcome, dates, and attach copies of any relevant documents:

15. **Have you ever** been diagnosed with, or treated for, a chronic physical illness and/or disability? No Yes
IF YES, provide complete details including dates and attach copies of any relevant documents:

16. **Are you aware** of any physical illness, mental illness and/or disability which affects, or could affect, your ability to practice medicine now or anytime in the future? No Yes
IF YES:
 a. Provide complete details including diagnosis/prognosis/dates and attach copies of any relevant documents:

b. Attach letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect your ability to practice medicine.

17. **Has any professional conduct or fee complaint ever** been filed against you with any Specialty, National, State or County Medical Society or other Professional Association? No Yes
IF Yes, describe circumstances, outcome and dates and attach copies of any relevant documents:

18. **Has any professional conduct or fee complaint ever** been filed against you with any licensing or regulatory authority? (e.g., AHCA/DPR/Board of Medicine or Health; Medicare/Medicaid; OSHA; EEOC; etc.) No Yes
IF YES, describe circumstances, outcome and dates:

II MEDICAL TRAINING AND HISTORY (continued)

19. **Have you ever** been charged with or convicted of a felony or misdemeanor for **other than** a minor traffic violation? No Yes

IF YES, describe circumstances, outcome, dates, and attach any relevant documents:

III INSURANCE HISTORY

20. Provide **complete** insurance history for past **10 (ten)** years beginning with your current insurance carrier. If there is an uninsured period, please write "uninsured" or "bare". Please be sure to explain any gaps in your coverage.

Name of Insurance Carrier	Policy Number	Prior Acts Date	Policy Limits	Deductible or SIR*?	Period of Coverage (Month/Day/Year)		Claims Trigger**
					From:	To:	
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand
				<input type="checkbox"/> No <input type="checkbox"/> Yes	From:	To:	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand

* SIR = Self Insured Retention ** Claims Trigger = Incident Driven allows incident reporting to trigger coverage; Written demand requires a written demand from the patient to trigger coverage.

21. Has your insurance for medical malpractice ever been canceled, suspended, non-renewed or declined?
 No Yes — Explain: _____

22. Have you ever had professional liability insurance provided by CNA? No Yes

23. Do you have any medically related duties that are insured by another company or for which you do not desire CNA Coverage?
 No Yes — Explain: _____

IV CURRENT MEDICAL PRACTICE

24. Are you practicing in a part-time, semi-retired, or limited capacity? No Yes

IF YES:

a. Provide date you began part-time practice: _____ / _____ / _____
MONTH DAY YEAR

- b. Provide total number of **hours per week** you devote to the following aspects of your practice:
- i. _____ Actual patient care
 - ii. _____ Patient record keeping
 - iii. _____ Administrative duties for your practice
 - iv. _____ After hours emergency care
 - v. _____ Hospital rounds
 - vi. _____ Returning patients' calls (including after hours)

c. Provide **reason(s)** why you are no longer engaged in a full-time practice **and** describe **activities** you are involved in, business related or otherwise, outside of your part-time practice.
 {e.g., **Reason(s)**: health/medical reasons; enables you to travel; spend more time with the family, etc. **Activities**: teaching/faculty appointment; involved in other than a medical related business (describe business); study for boards; work part-time elsewhere; etc.}

25. Percentage of your practice outside of your primary state? _____ %
 List States: _____

26. Percentage of your practice devoted to practicing as a locum tenens: _____ %

27. Practice structure / ownership information (please check all that apply):

You are a/an:

- | | |
|---|---|
| <p>a. No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Solo Practitioner</p> <p><input type="checkbox"/> <input type="checkbox"/> Solo Corporation</p> <p><input type="checkbox"/> <input type="checkbox"/> Solo Professional Association</p> <p><input type="checkbox"/> <input type="checkbox"/> Hospital Employee</p> <p><input type="checkbox"/> <input type="checkbox"/> Hospitalist</p> <p><input type="checkbox"/> <input type="checkbox"/> Independent Contractor</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: ↔ Describe: _____</p> | <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Shareholder or Stockholder of a multi-member corporation</p> <p><input type="checkbox"/> <input type="checkbox"/> Limited Liability Partnership</p> <p><input type="checkbox"/> <input type="checkbox"/> Medical Partnership, be it legal or "implied"</p> <p><input type="checkbox"/> <input type="checkbox"/> Using an assumed or fictitious name (i.e. a "DBA")</p> <p><input type="checkbox"/> <input type="checkbox"/> Employed by another individual or corporate entity</p> <p><input type="checkbox"/> <input type="checkbox"/> Employer of other physicians</p> |
|---|---|

b. For **other than a Solo Practitioner or Solo Corporation/Professional Association**, explain your relationship and provide complete, detailed information in regard to any items checked above.

For example:

- If a Hospitalist, Hospital employee or Independent Contractor, provide name of organization you are contracted with and/or employed by and explain scope of duties;
- If employed by, or contracted by, another individual or corporate entity, provide complete name of employer and/or entity with whom you are contracted by and explain scope of duties;
- If using an assumed or fictitious name (i.e. a "DBA"), provide complete "DBA" name;
- If employer of other physicians, provide complete/detailed list of employed physicians including their name, medical specialty and relationship to you.

Provide any additional information you feel will help clarify, or explain, items checked above. If additional space is needed, please write "see attached" and respond via separate attachment.

IV CURRENT MEDICAL PRACTICE (continued)

28. **Are you in a space-sharing arrangement or agreement** with another, or other, physician(s)? No Yes
IF YES, provide:

a. Name(s) of other physician(s) with whom you are space sharing:

b. How, **exactly**, does the sign to the entrance of the practice (i.e. the front door) read?

c. Do you share receptionist? No Yes

d. Do you share employees that provide medical care? No Yes

e. Do you have a common waiting room? No Yes

f. Are there common examination rooms? No Yes

g. Are patient charts for all space sharing physicians kept or retrieved from the same area? No Yes

h. Are there various letterheads being used by the physicians with whom you are space sharing? No Yes

IF YES, attach a copy of all letterheads being used by the physicians with whom you are space sharing.

i. Provide any additional information you feel will better help the company understand your space-sharing arrangement:
 If additional space is needed, please write "see attached" and respond via separate attachment.

29. a. **Are you professionally associated with** (either directly or indirectly), and/or do you provide professional services on behalf of (either directly or indirectly), and/or do you have a financial interest in, any of following. Please answer all.

No	Yes	Loc. Code #	Location Type	No	Yes	Loc. Code #	Location Type
<input type="checkbox"/>	<input type="checkbox"/>	01	Abortion Clinic	<input type="checkbox"/>	<input type="checkbox"/>	23	Industrial Firm Medical Care Facility
<input type="checkbox"/>	<input type="checkbox"/>	02	Administrative Position	<input type="checkbox"/>	<input type="checkbox"/>	24	Inpatient (bed/board) type Facility
<input type="checkbox"/>	<input type="checkbox"/>	03	Adult Congregate Living Facility	<input type="checkbox"/>	<input type="checkbox"/>	25	Massage Parlor/Establishment
<input type="checkbox"/>	<input type="checkbox"/>	04	Adult Day Care type Facility	<input type="checkbox"/>	<input type="checkbox"/>	26	Medical Laboratory
<input type="checkbox"/>	<input type="checkbox"/>	05	Ambulatory Surgery Center or Surgi-Center	<input type="checkbox"/>	<input type="checkbox"/>	27	Military Service (active or reserve)
<input type="checkbox"/>	<input type="checkbox"/>	06	Birthing Center	<input type="checkbox"/>	<input type="checkbox"/>	28	Nursing Home
<input type="checkbox"/>	<input type="checkbox"/>	07	Chemotherapy or Infusion Center	<input type="checkbox"/>	<input type="checkbox"/>	29	Occupational or Orthopaedic Rehab Center
<input type="checkbox"/>	<input type="checkbox"/>	08	College/University Sports (team or individual)	<input type="checkbox"/>	<input type="checkbox"/>	30	Palliative Care
<input type="checkbox"/>	<input type="checkbox"/>	09	Cruise Ship	<input type="checkbox"/>	<input type="checkbox"/>	31	Paramedical Services
<input type="checkbox"/>	<input type="checkbox"/>	10	Day Spa	<input type="checkbox"/>	<input type="checkbox"/>	32	Pharmacy
<input type="checkbox"/>	<input type="checkbox"/>	11	Developmentally Disabled Facility	<input type="checkbox"/>	<input type="checkbox"/>	33	Private Practice
<input type="checkbox"/>	<input type="checkbox"/>	12	Dialysis Center	<input type="checkbox"/>	<input type="checkbox"/>	34	Psychiatric Facility
<input type="checkbox"/>	<input type="checkbox"/>	13	Educational Institution	<input type="checkbox"/>	<input type="checkbox"/>	35	Radiology and/or Imaging Center
<input type="checkbox"/>	<input type="checkbox"/>	14	Facial Salon	<input type="checkbox"/>	<input type="checkbox"/>	36	Rehabilitation Facility
<input type="checkbox"/>	<input type="checkbox"/>	15	Fitness Center	<input type="checkbox"/>	<input type="checkbox"/>	37	Sanatorium
<input type="checkbox"/>	<input type="checkbox"/>	16	Governmental Entity	<input type="checkbox"/>	<input type="checkbox"/>	38	Semi or Professional Sports (team or individual)
<input type="checkbox"/>	<input type="checkbox"/>	17	Grade or High School Sports (team or individual)	<input type="checkbox"/>	<input type="checkbox"/>	39	Tattoo Parlor/Establishment
<input type="checkbox"/>	<input type="checkbox"/>	18	Hair Restoration or Laser Hair Removal Clinic	<input type="checkbox"/>	<input type="checkbox"/>	40	Urgent Care or E-Care type facility
<input type="checkbox"/>	<input type="checkbox"/>	19	Home Health Care Services	<input type="checkbox"/>	<input type="checkbox"/>	41	Vein Clinic
<input type="checkbox"/>	<input type="checkbox"/>	20	Hospital-Based Practice	<input type="checkbox"/>	<input type="checkbox"/>	42	Walk-In Clinic
<input type="checkbox"/>	<input type="checkbox"/>	21	Hotel	<input type="checkbox"/>	<input type="checkbox"/>	43	Weight Loss Center
<input type="checkbox"/>	<input type="checkbox"/>	22	Other(s) ↻ please explain:				

b. **Please use this space to** explain your professional and/or financial relationship with each of the above. If additional space is needed, please write "see attached" and respond via separate attachment.

IV CURRENT MEDICAL PRACTICE (continued)**34. Telemedicine, E-Commerce Medicine, Internet Medicine and/or Internet Prescribing**

- a. Do you perform/provide consultations, diagnose and/or treat, provide medical advice and/or opinions, review slides or specimens, prescribe medications, sell any products (as a distributor or for products you make, produce and/or manufacture), or sell any type of services via telecommunications, video, electronic information systems or the Internet? No Yes

IF YES:

- i. Explain/describe services in detail (if additional space is needed, please write "see attached" and respond via separate attachment):

- ii. List states services in which services are provided:

- iii. Do you adhere to standards relating to telemedicine set forth by professional organizations such as the American College of Radiology, Standard for Teleradiology, the American Telemedicine Association, including licenser? No Yes

Explain: _____

- b. Have you agreed, via contract or otherwise, to be the prescribing physician for an Internet site/service not directly associated with your private practice? No Yes

IF YES, please respond to the following:

- i. Do you prescribe drugs based solely on an electronic medical questionnaire? No Yes
- ii. Do you do this for more than one Internet site? No Yes
- iii. Provide all applicable web page/internet address(es):

- c. Do you practice telemedicine services described above across international lines? No Yes

If yes, please list countries:

35. Do you now, OR have you ever, provided professional services on behalf of a jail, prison, correctional facility, detention center, halfway house or similar type facility for adults and/or juveniles? No Yes

IF YES:

- a. Do you currently provide services on behalf the above described facilities? No Yes

- i. **IF YES**, provide total number of hours per month: _____

- ii. Complete details including "duties/services/when/where":

- b. Have you in the past provided services on behalf of above described facilities? No Yes

- i. Complete details including "duties/services/when/where":

IV CURRENT MEDICAL PRACTICE (continued)

36. Approved and non-approved FDA drugs / devices / procedures

If additional space is needed, please write "see attached" and respond via separate attachment.

- a. Do you perform any procedures/surgeries considered to be experimental in nature **and/or** not currently approved by the FDA? No Yes
IF YES, please provide complete details:

- b. Are you involved/associated with any devices, including implants, considered to be experimental **and/or** not currently approved by the FDA? No Yes
IF YES, please provide complete details:

- 37. Are you associated with (directly or indirectly), or do you participate in, TV reality shows** whose primary focus is to physically alter the looks of individuals who have either won a place on the show or who have been selected to be a participant in the show? No Yes

- 38. a.** Do you have hospital privileges? No Yes

Hospital Name	City, County, State	Type of privilege	
		<input type="checkbox"/> Full	<input type="checkbox"/> Courtesy
		<input type="checkbox"/> Restricted	<input type="checkbox"/> Other*
		<input type="checkbox"/> Full	<input type="checkbox"/> Courtesy
		<input type="checkbox"/> Restricted	<input type="checkbox"/> Other*
		<input type="checkbox"/> Full	<input type="checkbox"/> Courtesy
		<input type="checkbox"/> Restricted	<input type="checkbox"/> Other*

- b.** If you do not currently have hospital privileges:
- i. describe the referral method you use if a patient requires hospital admission:

- ii. list names of other physicians willing to accept your patients for hospital admission:

- c.** Have your hospital privileges ever been suspended, denied, revoked, restricted or otherwise sanctioned? No Yes — Explain: _____

- d.** Do you work in the emergency department other than to fulfill requirements for your hospital privileges? No Yes — List number of hours per week: _____

IV CURRENT MEDICAL PRACTICE (continued)

39. Office Surgery and Anesthesia

- a. Do you follow/adhere/comply with all guidelines and standards for office space surgery as defined by the American Society of Anesthesiologists and the American College of Surgeons: No Yes
- b. Do you (or will you) perform, or assist with, any **Level II and/or Level III** surgical procedure at **other than** a Hospital? No Yes
- c. Do you (or will you) administer anesthesia (and/or supervise anyone administering anesthesia) for any **Level II and/or Level III** surgical procedure performed at **other than** a Hospital? No Yes
- d. Do you maintain any overnight facilities in your office? No Yes
- e. **IF YES to 'b' and/or 'c' above**, complete the following:
 - i. Do you have privileges at a local hospital for **all** procedure(s) performed and/or anesthesia administered (administering anesthesia includes the supervising of anyone administering anesthesia)? No Yes
IF NO, please explain:

 - ii. Anesthesia is administered by whom (e.g., yourself, Anesthesiologist, CRNA, contracted, etc.):

 - iii. Do you maintain a full emergency/crash cart? No Yes
IF YES, is a protocol in place for checking the cart on a regular basis? No Yes
 - iv. Name of, and distance to, nearest hospital with emergency services:

40. Which of the following describes your practice?

- No Surgery** — perform neither surgery nor obstetrical procedures. Incising of boils and superficial fascia, suturing of minor lacerations, removal of superficial skin lesions by other than surgical excision and assisting in surgery are not considered surgery.
- Minor Surgery** — applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following medical techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive), tonsillectomies, and adenoidectomies.

Please list types of procedures routinely performed: _____

- Major Surgery** — includes operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen, pelvis or any other operation which because of the condition of the patient or length of the circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures, amputations, termination of pregnancy, the removal of any gland or organ (excluding tonsillectomies and adenoidectomies), plastic surgery and any operation done using general anesthesia.

Number per year: _____

Please list types of procedures routinely performed: _____

IV CURRENT MEDICAL PRACTICE (continued)

Bariatric Surgery

What procedures do you utilize for bariatric surgery? _____

What percent of your practice is devoted to bariatric surgery? _____ %

How many procedures do you perform a year? _____

Do you perform bariatric surgery on minors? No Yes

41. Please answer the following. If you answer yes to any question with asterisks(**), please explain fully on your letterhead.

Do you perform the following procedures?

- A. Elective cosmetic surgery No Yes — percentage of practice: _____ %
- B. Itinerant surgery No Yes **
- C. Vaginal deliveries No Yes — number per year: _____
- D. Cesarean sections No Yes — number per year: _____
- E. Deliveries outside the hospital No Yes **
- F. Abortions No Yes — percentage of practice: _____ %
- G. Neonatology No Yes — percentage of practice: _____ %
- H. Professional sports medicine No Yes **
- I. Angiography/arteriography/
cardiac catheterization No Yes
- J. Experimental procedures No Yes **
- K. Weight control surgery/drugs No Yes ** percentage of practice: _____ %
- L. Acupuncture No Yes — percentage of practice: _____ %
- M. Chemical Peels No Yes — percentage of practice: _____ %
- N. Clinical Trials No Yes — percentage of practice: _____ %
- O. Collagen injections No Yes — number per year: _____
- P. Colonoscopy No Yes
- Q. Needle Biopsies No Yes
- R. Organ Transplants No Yes
- S. Penile Implants No Yes
- T. Reconstructive Plastic Surgery No Yes
- U. Sex change operations No Yes
- V. Hypnosis No Yes
- W. Laser therapy No Yes **
- X. If you are a primary care physician, do you automatically receive the results of tests and consultation/exam reports ordered by the physician/surgeon to whom your patient was referred?
 No
 Yes — How quickly do you receive them? _____

IV CURRENT MEDICAL PRACTICE (continued)

42. a. Average number of patients seen per week: _____
 b. Do you accept "walk-in" patients? No Yes
 c. Percentage of practice of "walk-in" patients: _____
43. Average number of hours practiced per week. The number of hours practiced per week should include all aspects of your practice and not limited to the number of hours you spend "one on one" with a patient.
NOTE: "All aspects of your practice" should include time spent on: patient record keeping; administrative duties for your practice; after hours emergency care; hospital rounds; returning patients' calls; etc. _____
44. Provide approximate percentage of your patient clientele makeup in the following categories. Show "0" or "N/A" if "none".
 a. _____ % Auto Insurance (e.g., auto accident victims) e. _____ % Disability and/or Independent Medical Evaluations
 b. _____ % Medicare/Medicaid patients f. _____ % Direct pay by patient and/or fee for service
 c. _____ % Work Comp g. _____ % Managed Care HMO/IPA/PPO patients
 d. _____ % Other: ↔ Describe: _____
45. Advertising methods
 a. Please check all methods of advertising used:
- | | | | | |
|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| No | Yes | | No | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> | Brochures | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Direct Mail | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Flyers | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Handouts | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Internet ↔ Web Address: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Other, please explain: _____ | <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"/> |
- b. Attach copy of materials for all checked above including copies of scripts for voice and/or film media.

V CLAIMS HISTORY

- NOTE:** ➤ If you are requesting Prior Acts Coverage (aka retroactive or nose coverage), you must report all potential claims, suits, and/or incidents to your current insurance carrier before the underwriting process can continue. Some of the questions below have been designed to help you recall these types of circumstances / incidents.
- Please read the following questions (and sub-questions) carefully. Questions "a" and "b" are self-explanatory. Questions "c" and "d", while similar sounding, pose two distinctly different questions.

- a. **Has your present or any past insurance carrier(s) ever refused or declined to accept your report of a claim or threat of a claim, adverse result, request for patient records, attorney contact, medical incident, suit, notice of intent to litigate, or any other similar type report?** No Yes
IF YES, please complete the following:
 i. How many such reports have there been (note: the "count" should be 1 per refused or declined report)? _____
 ii. A **Claim / Incident / Suit Supplement Form** must be completed for **each**.
 iii. Attach copy of the original report(s) as well as a copy of the correspondence received from the carrier for **each**.
- b. **Has any claim or suit for alleged malpractice ever been brought/filed against you or are you presently involved in malpractice litigation either directly or indirectly?** No Yes
IF YES, a **Claim / Incident / Suit Supplement Form** must be completed for **each**.



AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

I hereby request that my Application for insurance coverage under the provisions of the Physicians' Protection Program be submitted for consideration to CNA and its affiliates. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to CNA and its affiliates any and all information requested which may relate to my insurability under the Physicians' Protection Program.

I hereby warrant and represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my protection.

I hereby consent to the review of my Application by the committees appointed by my state medical association/society. I agree to cooperate with these committees.

I hereby consent to disclosure by CNA to the committee appointed by my state medical association/society to review any of my closed claim files and any settlements or judgments that may be deemed confidential.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Signature in Full

Date

Name - Please print

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

This program is underwritten by and Application is made to one of the CNA Insurance Companies. CNA is a registered service mark of the CNA Financial Corporation.