J. P. Anthony Agency, LLC 901 Route 168/Suite 110 Turnersville, NJ 08012	APPLICATION PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS (CLAIMS-MADE FORM)

Applicant's Instructions:
1. If you have a Curriculum Vitae (C.V.), please attach to application and check here _____.
2. Please do not complete application earlier than 45 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT IN INK)

1. A. Name of Applicant _____ Degree _____

   B. Social Security No. _____

   C. Date of Birth _____ Place of Birth _____

   D. Are you a U.S. Citizen? _____ Yes _____ No. If "No", please indicate your status and date of entry into USA on separate sheet and attach

2. A. Principal Office: _____
   No. Street City County State Zip

   Phone: ( ) _____

   B. Other Offices? (If any) _____ Phone: ( ) _____
   _____ Phone: ( ) _____

3. A. Limits of Liability Desired: $,000. Each claim
   (Limits in policy will govern coverage) $,000. Aggregate
   B. Amount of deductible desired: $ _____

4. Desired Effective Date (12:01 a.m.): _____

5. I practice as: _____ Solo Practitioner (unicorporated) _____ Solo Practitioner (incorporated)
   _____ Professional Association _____ Partnership
   _____ Professional Corporation _____ Employee of _____
   (give name)

6. If you practice other than as an <u>employee</u> OR <u>unincorporated</u> solo practitioner:

   A. List the names of ALL your partners, your employees, or members or your professional association or corporation who practice medicine: _____
   _____

   B. Give the formal corporate, association, partnership or business name:
   _____

   C. Attach a copy of your letterhead.

7. List states and license numbers where you practice _____
   _____

8. A. List hospitals at which you are currently a staff member and show % of work at each hospital.
   1. _____ _____%
   2. _____ _____%
   3. _____ _____%

   B. Briefly describe type and extent of your hospital privileges: _____
   _____

   D. Are you Chief or Head of a hospital department? _____ Yes _____ No

9. Do you or the firm listed in Question 6.B. above own (wholly or in part) operate, or administer any hospital, nursing home, or other institution where medical services are customarily rendered? _____ Yes _____ No. If yes, give details, including name, location, size and number of beds.

CURRENT PRACTICE

10. A. What is your medical or surgical specialty? _____
B. Do you limit your practice to the above specialty? _____ Yes _____ No
C. Do you have a sub-specialty? _____ Yes _____ No. If yes, describe: _____
_____

11. Do you perform one or more of the following:

	YES	NO
A. Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)? If "yes", describe below. If you perform any minimal incision surgery, check here _____ _____ _____	A. _____	_____
B. Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel)? Describe: _____	B. _____	_____
C. Arteriography/lymphangiography/myelography/phenmoencephalography?	C. _____	_____
D. Interventional radiology-percutaneous transluminal angioplasty or embolization?	D. _____	_____
E. Radiation therapy – deep (includes radium implants)?	E. _____	_____
F. Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces?	F. _____	_____
G. Mohs micrographic surgery? Describe: _____	G. _____	_____
H. Acupuncture (for analgesia) or Acupuncture anesthesia? Describe: _____ _____	H. _____	_____
I. Prenatal care and normal deliveries? If "yes", Do you perform home deliveries? _____Yes _____ No Do you only perform prenatal care? _____ Yes _____ No Do you supervise nurse midwives? _____ Yes _____ No. If "yes", indicate when you refer: _____ weeks gestation	I. _____	_____
J. Dilation and currettage?	J. _____	_____
K. Needle biopsies? Describe: _____	K. _____	_____
L. Electroshock therapy or hypnosis? Describe: _____	L. _____	_____
M. Radial keratotomy? Indicate where performed: _____Hospital _____ Office _____ Surgicenter	M. _____	_____
N. Hexagonal keratotomy? Indicate where performed: _____ Hospital _____ Office _____ Surgicenter	N. _____	_____

12. Do you perform any one or more of the following:

	YES	NO
A. Surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia?	A. _____	_____
B. Non-spontaneous, induced abortions? _____ 1st trimester (Not exceeding 14 weeks gestation) _____ 2nd trimester (indicate where performed: _____ Hospital _____ Office _____ Surgicenter	B. _____	_____
C. Sterilization procedures? Describe: _____	C. _____	_____
D. Cosmetic plastic surgery, cosmetic body contouring (Suction lipectomy), Implantations, injections and/or blepharopigmentation? Describe: _____ _____	D. _____	_____
E. Spinal surgery. If you also perform chemonucleolysis, check here _____ and/or percutaneous lumbar discectomy, check here _____	E. _____	_____
	YES	NO
F. Open reduction of fractures? Describe: _____	F. _____	_____

G. Administration of general, spinal or caudal block anesthesia? G. _____ _____

H. Hysterectomies? Do you perform laparoscopic hysterectomies? H. _____ _____

I. Cholecystectomies? Do you perform laparoscopic cholecystectomies? I. _____ _____
Indicate number of laparoscopic cholecystectomies performed to date _____

J. Tonsillectomies and/or Adenoidectomies? J. _____ _____

K. Caesarian sections? K. _____ _____

L. Organ transplantations? Describe: _____ L. _____ _____

M. Weight reduction surgery? M. _____ _____

N. Sex change operation? Describe: _____ N. _____ _____

O. Experimental research or surgical research or experimental therapy in human patients? Describe: _____ O. _____ _____

P. Other surgery? Describe: _____ P. _____ _____

13. A. Do you perform surgery in your office? _____ Yes _____ No. If "yes", list surgical procedures: _____

B. Do you perform surgery in other non-hospital facilities? _____ Yes _____ No. If "yes", list facilities and surgical procedures:_____
_____

C. In course of surgery (described in A or B above) is general anesthesia administered? By you? _____ Yes _____ No, By others? _____ Yes _____ No

14. A. Indicate number of <u>hours per month</u> devoted to hospital emergency room care: _____ hours per month

B. Is this emergency room care:
1. On you own patients only? _____ Yes _____ No
2. Required for staff privileges _____ Yes _____ No
3. Other _____ _____ Yes _____ No

15. Do you assist in surgery: On your own patients? _____ Yes _____ No. Patients of others? _____ Yes _____ No

16. If your practice includes plastic surgery, specify percent of practice devoted to traumatic surgery _____%; cosmetic surgery _____%

17. Do you practice weight reduction or control (other than by diet-exercise)? _____ Yes _____ No. If "yes", percent of patients exclusively weight control _____% Do you dispense (as opposed to prescribe) any weight control drugs? _____ Yes _____ No. If "yes", list drugs dispensed _____

Do you use injections for weight control? _____ Yes _____ No. If "yes", list drugs injected: _____
_____

18. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? _____ Yes _____ No. If "yes", please attach detailed explanation of this activity.

19. A. List number and type of professional employees: IF NONE, STATE NONE.
_____ Physicians (other than yourself) _____ Surgeon's Assistants*
_____ Nurse Practitioners*/Physician's Assistants*
_____ Nurse Anesthetists _____ Other (describe) _____

* Describe duties in detail, including extent supervised, on separate sheet

B. Are all of the above individuals licensed in accordance with applicable state and federal regulations? _____ Yes _____ No. If "no", attach explanation.

20. Have you or any of the above employees: (Attach detailed explanation for any "yes" answers)

YES NO

A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable.) A. _____ _____

B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? B. _____ _____

C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction? C. _____ _____

D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? D. _____ _____

E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? E. _____ _____

F. Ever failed any medical licensing or specialty organization examination? F. _____ _____

G. Do you have any chronic physician illness or defect? G. _____ _____

21. Do you supervise any individuals other than your own employees? _____ Yes _____ No. If "yes", provide detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-Ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

22. Are you in the employ of any individual, firm or corporation other than your own? _____ Yes _____ No. If "yes", attach explanation, including details of any responsibilities.

23. Are you under contract to any individual, firm or corporation other than your own? _____ Yes _____ No. If "yes", attach explanation including details of your responsibilities. If this contract contains a hold-harmless agreement copy of contract must be attached to application.

24. Are you in the employ of or under contract to any government entity? _____ Yes _____ No. If "yes", attach explanation, including details of your responsibilities.

25. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? _____ Yes _____ No. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? _____ Yes _____ No. If "yes", submit copy of ALL the advertisements.

26. A. From what medical school did you graduate? _____
Degree: _____ Year: _____
Location of medical school _____
(City) (State) (Country)

B. If foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates? _____ Yes _____ No. If "yes", state year and describe: _____
_____

C. Residency? _____ Yes _____ No. If "yes", complete the following for each residency served:
Location _____ From _____ To _____ Type _____
Completed? _____ Yes _____ No
Location _____ From _____ To _____ Type _____
Completed? _____ Yes _____ No

D. Additional Medical Training? _____ Yes _____ No. If "yes", complete the following:
Location _____ From _____ To _____
Type _____

27. Are you American Board certified? _____ Yes _____ No
Medical Specialty _____ Date Certified ___/___/___ Recertified ___/___/___

28. Where have you practiced your profession since completion of training:
In _____ From _____ To _____
In _____ From _____ To _____
In _____ From _____ To _____

29. Indicate membership in professional societies: _____
_____

30. Have you participated in any continuing medical educational program within the past five years?
_____ Yes _____ No. If "yes", describe separately.

31. Do you or the firm named in Question 6.B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? _____ Yes _____ No. If "yes", attach detailed explanation.

32. A. Has any claim or suit for alleged malpractice been brought against the applicant? _____ Yes _____ No. If "yes" how many_____? *Please complete the **Claim Supplemen**t* and provide currently valued company loss runs for the past 7 years.

B. Has any claim or suit for alleged malpractice been made against the applicant that has NOT been reported to a prior Insurer? _____ Yes _____ No. . If "yes" how many _____? *Please complete the **Claim Supplemen**t* and provide currently valued company loss runs for the past 7 years.

C. Is the applicant aware of any acts, errors, omissions or circumstances which may result in a malpractice claim, or suit being made or brought against the applicant? _____ Yes _____ No. . If "yes" how many _____? *Please complete the **Claim Supplemen**t* and provide currently valued company loss runs for the past 7 years.

33. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hr. walk-in clinic or birthing center? _____ Yes _____ No. If "yes", state location and describe _____
_____

34. A. Average patient load: _____ Patients Weekly _____ Total Patients Annually

B. Average number of hours practice time: _____ Hours weekly

35. Do you anticipate changes in your practice in the next 12 months? _____ Yes _____ No. If "yes", explain _____
_____

36. Approximate gross annual income from the practice (check one):
_____ Less than $50,000. _____ $100,000 - $149,999 _____ $200,000 or more (please estimate)
_____ $50,000 - $99,999 _____ $150,000 – 199,999

37. List prior professional liability insurance carried to each of the past five years. If NONE, check here _____.

INSURANCE COMPANY	LIMITS OF LIABILITY	PREMIUM	INCEPTION MO/DAY/YR	EXPIRATION MO/DAY/YR	RETROACTIVE MO/DAY/YR	WAS THIS A CLAIMS MADE POLICY FORM? YES	NO
1.							
2.							
3.							

ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR MOST RECENT COVERAGE.

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

_____ _____
Date Signature of Applicant Title