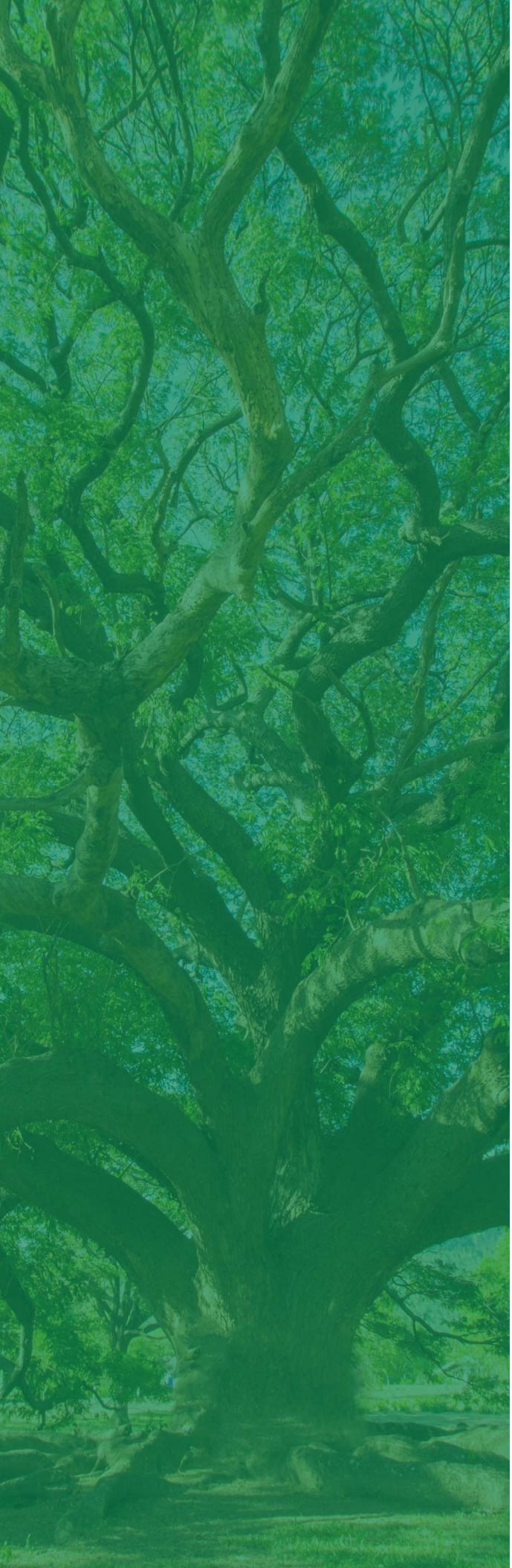

PHYSICIANS
PROTECTOR PLAN®

PracticePRO℠

MEDICAL PROFESSIONAL AND CYBER LIABILITY INSURANCE SOLUTION FOR TODAY'S PHYSICIAN PRACTICES

Aspen

ASPEN AMERICAN INSURANCE COMPANY

APPLICATION DISCLOSURE AND INSTRUCTIONS

CLAIMS-MADE DISCLOSURE NOTICE: THIS IS AN APPLICATION FOR CLAIMS-MADE AND REPORTED INSURANCE PROVIDED THROUGH ASPEN AMERICAN INSURANCE COMPANY (THE "COMPANY"). IT IS IMPORTANT THAT THE APPLICANT REPORT ANY CURRENTLY KNOWN CLAIMS OR CIRCUMSTANCES THAT COULD RESULT IN A CLAIM TO THE APPLICANT'S CURRENT INSURER OR PURCHASE AN EXTENDED REPORTING PERIOD TO COVER SUCH CLAIMS OR INCIDENTS. THE COMPANY WILL NOT PROVIDE COVERAGE FOR CLAIMS OR INCIDENTS WHICH THE APPLICANT IS AWARE OF PRIOR TO THE INCEPTION DATE OF ANY COVERAGE THAT IS OFFERED AND ACCEPTED.

You agree that any coverage issued will be contingent upon the truth of the information provided in this application. If a policy is issued, this application will become a part of the policy, as if physically attached thereto.

Please fully complete this application as an incomplete application cannot be evaluated. Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply. Provide any supporting information on a separate sheet and reference the applicable question number. This application must be completed, dated and signed by an authorized representative of the applicant.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the policy, if and when issued.

REQUIRED ATTACHMENTS:

Please include copies of the following documents with your application:

- ☐ Curriculum vitae (CV).
- ☐ Declarations Page from your current applicable insurance policies.
- ☐ Currently valued loss runs from all insurance carriers over the last seven years.
- ☐ Explanations to any application questions which require additional sheets of paper.

GENERAL INFORMATION

1. Name (First, Middle, Last):_____ ☐ M.D. ☐ D.O.
2. Date of Birth: _____ 3. Gender: ☐ Male ☐ Female
4. Mailing Address: _____
5. Primary Practice Address: _____
6. Office Telephone: _____
7. Email Address: _____
8. Office Website: _____

MEDICAL PROFESSIONAL LIABILITY INSURANCE INFORMATION

9. Requested effective date: _____ 10. Requested Prior Acts Date: _____

11. If prior acts coverage is not requested, are you purchasing extended reporting (tail) coverage from your current carrier?..... ☐ Yes ☐ No
    If **"NO",** please explain: _____

12. Requested limits of insurance:

    Per Claim: _____ Aggregate: _____

13. Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage? ..... ☐ Yes ☐ No
    If **"Yes",** please describe the nature of the professional activities as well as the name of the relevant insurance company: _____
    _____

14. Have you ever practiced medicine without insurance?..... ☐ Yes ☐ No
    If **"Yes",** please explain: _____
    _____

15. Beginning with your most recent or current insurer, please list all professional liability insurers for the past seven (7) years:

NAME OF INSURER	COVERAGE TYPE (OCCURRENCE OR CLAIMS-MADE)	LIMITS OF LIABILITY	POLICY PERIOD	PREMIUM

PRACTICE INFORMATION

16. Primary Specialty: _____ Subspecialty (if any): _____

17. Is your practice limited to your specialty and/or subspecialty? ..... ☐ Yes ☐ No
If **"No",** please explain: _____
_____

18. Please provide a general overview of the nature of your practice: _____
_____
_____

19. Please provide ABMS (American Board of Medical Specialties) and/or AOA (American Osteopathic Association) Certification Information:

Name of ABMS or AOA Specialty Board:	Status: Yes / No / N/A Certified	Eligible	Date Certified	How many times was exam taken? Orals	Written	Date Eligibility Expires	Maintenance of Cert (Y/N)

If you are **not ABMS** or **AOA** certified, do you intend to pursue certification? ☐ Yes ☐ No

If **"Yes",** provide expected exam date(s): _____

If **"No",** please explain why: _____
_____

If you were previously ABMS or AOA certified but did not maintain your certification, please explain why:
_____

20. List all practice locations for which you are requesting coverage and notate the description for each (i.e. medical office, surgery center, hospital, nursing home, etc.):

PRACTICE ADDRESS	DESCRIPTION

21. List all states where you are licensed:

STATE	LICENSE NUMBER	ACTIVE/INACTIVE	% OF PRACTICE

22. Please provide all hospitals and surgi-centers at which you have maintained privileges in the past five (5) years and estimate the percentage of admissions for each:

NAME	CITY	STATE	TYPE OF PRIVILEGES	% OF ADMISSIONS

23. If you do not have hospital privileges, explain why and identify what process is used for patients requiring hospitalization: _____

24. Do you practice as a Hospitalist? ..... ☐ Yes ☐ No

25. Do you work in an emergency room? ..... ☐ Yes ☐ No
If **"Yes",** how many hours per week and for what institution? _____

26. Do you provide professional services on behalf of or in association with any nursing home or correctional facility? ..... ☐ Yes ☐ No
If **"Yes",** please explain: _____

27. Do you have any Medical Director responsibilities? ..... ☐ Yes ☐ No
If **"Yes",** please explain: _____

28. Are you a sports team physician for any professional or collegiate sports team? ..... ☐ Yes ☐ No
If **"Yes",** please explain: _____

29. What protocols do you have in place to monitor and audit HIPAA compliance in your office? _____
_____

30. Average number of patients seen per week: _____

31. Are you currently working 20 hours or less per week? ..... ☐ Yes ☐ No
IF **"YES",** PLEASE COMPLETE A *PART-TIME SUPPLEMENT*.

32. Does your practice offer concierge/retainer medicine or do you collect annual fees/retainers from patients? ..... ☐ Yes ☐ No

33. Do you maintain your patient records in an electronic medical record? ..... ☐ Yes ☐ No
If **"Yes",** who is your EMR provider? _____

34. Do you maintain a website or other social media presence? ..... ☐ Yes ☐ No
If **"Yes",** do you offer online consultations? ..... ☐ Yes ☐ No

PROCEDURES

35. Please check all procedures you perform or have performed within the requested retroactive period:

- ☐ Abortions – first trimester:
  - ☐ Hospital ☐ Clinic ☐ Office
- ☐ Abortions – after first trimester:
  - ☐ Hospital ☐ Clinic ☐ Office
- ☐ Acupuncture
- ☐ Adenoidectomies
- ☐ Addiction Medicine
  - ☐ Suboxone Therapy
- ☐ Anesthesia – obstetrical:
  - ☐ General ☐ Spinal ☐ Epidural
- ☐ Anesthesia – non-obstetrical:
  - ☐ General ☐ Spinal ☐ Epidural
  - ☐ Anesthesia (other) – Please describe:

  _____
- ☐ Angiographies
- ☐ Angioplasty
- ☐ Appendectomies
- ☐ Arteriographies
- ☐ Assisting in major surgery – own patients
- ☐ Bariatric Surgery
  - ☐ Gastric Bands
  - ☐ Bypass or Staples
  - ☐ Gastric Sleeve
  - ☐ Other: _____
- ☐ Botox and/or Dermal Fillers (elective cosmetic)
- ☐ Breast implants
- ☐ Breast reductions
- ☐ Catheterizations:
  - ☐ Cardiac
  - ☐ Arterial
  - ☐ Other – Please describe: _____

  _____
- ☐ Chelation therapy
- ☐ Chemabrasion
- ☐ Chemical Peels
- ☐ Chemotherapy
- ☐ Colonoscopies
- ☐ Cosmetic implantation or injection of silicone or other materials. Please describe: _____

  _____
- ☐ Cryosurgery – Please describe: _____

  _____
- ☐ D & C's
- ☐ Deliveries:
  - ☐ Vaginal ☐ Cesarean ☐ Vaginal after Cesarean
- ☐ Electromyography
- ☐ Endoscopy (other than proctoscopy or sigmoidoscopy):

  _____
- ☐ Eyeliner or Eyebrow pigmentation
- ☐ Fracture reductions – closed
- ☐ Fracture reductions – open
- ☐ Hair transplants, or other hair restoration techniques
- ☐ Hemorrhoidectomies:
  - ☐ Internal ☐ External
- ☐ Herniorrhaphies
- ☐ In vitro fertilization (IVF)
- ☐ Laparoscopy:
  - ☐ Diagnostic – Please describe: _____

    _____
  - ☐ Surgical – Please describe: _____

    _____
- ☐ Laser Surgery – Please indicate type of surgery:

  _____
- ☐ Laser refractive eye procedures:

  # Patients Annually: _____
- ☐ Liposuction – Please describe: _____

  _____
- ☐ Lumbar punctures
- ☐ Manipulation therapy
- ☐ Needle aspirations
- ☐ Needle biopsies
- ☐ Neonatology
- ☐ Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts. Please indicate type of surgery:

  _____
- ☐ Pacemaker insertion
- ☐ Pain management – Please indicate type:

  _____
- ☐ Pre-natal care
- ☐ Radial keratotomies
- ☐ Radiation – diagnostic
- ☐ Radiation – therapeutic
- ☐ Sclerotherapy (choose one) ☐ <1mm ☐ >1mm
- ☐ Shock therapy
- ☐ Spinal Surgery
- ☐ Tattoo removal
- ☐ Thoracentesis
- ☐ Tonsillectomies
- ☐ Total joint replacements
- ☐ Tubal ligations
- ☐ Vasectomies
- ☐ Venography
- ☐ Any other procedure you reasonably believe will be of interest to a medical professional liability insurer:

  _____
- ☐ **I DO NONE OF THESE PROCEDURES**

HEALTH CARE PROVIDER INFORMATION

36. Please list any employed physician extenders* to be insured on your professional liability insurance policy:

NAME	SPECIALTY	PRACTICE LOCATION	RETROACTIVE DATE	DATE OF HIRE	LIMITS OF LIABILITY	20 HOURS OR LESS PER WEEK
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

IF COVERAGE IS DESIRED FOR ANY **EMPLOYED PHYSICIAN EXTENDER IDENTIFIED ABOVE, PLEASE SUBMIT A COMPLETED ALLIED HEALTH CARE PROVIDER APPLICATION.*

37. **Vicarious Liability Coverage**: Please list any physicians or physician extenders with whom you contract to provide services and who are not scheduled for coverage on your professional liability insurance policy:

NAME	SPECIALTY	PRACTICE LOCATION	VICARIOUS LIABILITY COVERAGE DESIRED?	CERTIFICATE OF INSURANCE ON FILE?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

ORGANIZATION/ENTITY INFORMATION

38. Under which business structure do you practice? Check all that apply:

☐ **Employee**
Name of employer: _____

☐ **Independent Contractor**
Name of hiring party to contract: _____

☐ **Individual / Solo Practice**
Name of solo professional corporation (if applicable): _____

☐ **Partnership / Shareholder in multi-physician owned corporation**
Name of corporation: _____

39. Do you desire coverage for your legal entity? ..... ☐ Yes ☐ No
If **"Yes",** please complete the following:

CORPORATION NAME	LIST ALL OWNER PHYSICIANS	CORPORATION PRIOR ACTS DATE	LIMITS OF LIABILITY
	1) _____ 2) _____ 3) _____ 4) _____		☐ Shared ☐ Separate: _____

40. Do you have an ownership interest in any other legal entity or partnership other than those listed above or do you have any affiliation with any other healthcare related organization not previously disclosed on this application? ..... ☐ Yes ☐ No

MEDICAL PROFESSIONAL LIABILITY UNDERWRITING INFORMATION

For questions 41 -57, please explain any "Yes" responses on a separate sheet of paper.

41. Has any professional society or association ever refused, suspended or revoked your membership? ..... ☐ Yes ☐ No
42. Has any state ever refused to issue you a license to practice medicine? ..... ☐ Yes ☐ No
43. Has any state ever restricted, suspended or revoked your license to practice medicine?..... ☐ Yes ☐ No
44. Have you ever voluntarily surrendered a license to practice medicine? ..... ☐ Yes ☐ No
45. Has any state agency ever placed you on probation or restricted your practice?..... ☐ Yes ☐ No
46. Have you ever been the subject of an investigation by any governmental agency?..... ☐ Yes ☐ No
47. Have your hospital privileges ever been surrendered, restricted or revoked whether voluntarily or involuntarily?..... ☐ Yes ☐ No
48. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? ..... ☐ Yes ☐ No
49. Are you now being, or have you ever been, treated for, or suffered from, alcoholism or other chemical dependency? ..... ☐ Yes ☐ No

    *If **"Yes",** please provide details of rehabilitation program including dates of treatment.*

50. Have you ever incurred or become aware of any illness, or physical, emotional or mental health condition or disability that impairs, or could impair, your ability to practice medicine? ..... ☐ Yes ☐ No

    *If **"Yes",** please provide a physician's statement attesting to your fitness to practice.*

51. Have you ever had allegations of sexual misconduct made against you? ..... ☐ Yes ☐ No
52. Have you ever been convicted, had charges brought against you, or are you currently under investigation for a crime other than a traffic offense? ..... ☐ Yes ☐ No
53. Have you ever been refused board certification?..... ☐ Yes ☐ No
54. Have you ever had professional liability insurance declined, canceled or non-renewed?..... ☐ Yes ☐ No
55. Do you use any non-FDA approved devices, drugs or procedures?..... ☐ Yes ☐ No
56. Has any claim or suit for alleged malpractice ever been brought against you? ..... ☐ Yes ☐ No

    If **"Yes":** Number of closed claims: _____ Number of open claims: _____

    Please complete a Claim Supplement for each open or closed claim in the last 10 years.

57. Are you aware of any circumstances that could reasonably lead to a claim or suit, or have you received a request for medical records from a patient's legal representative? ..... ☐ Yes ☐ No

    If **"Yes",** have these been reported to your current professional liability insurer? ..... ☐ Yes ☐ No

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PRIVACY AND NETWORK SECURITY INSURANCE INFORMATION

58. **IF** a higher limit of Privacy and Network Security insurance is desired, please select one of the limit options below. **IF** higher limits are **not** desired, you may skip this section.

	Option 1	Option 2	Option 3
PRIVACY & NETWORK SECURITY AGGREGATE LIMIT	**$250,000**	**$500,000**	**$1,000,000**
COVERAGE PARTS WITH SUB-LIMITS:			
LIABILITY AND RESTORATION COVERAGE	$250,000	$500,000	$1,000,000
INCIDENT RESPONSE EXPENSE COVERAGE	$250,000	$500,000	$1,000,000
PAYMENT CARD COVERAGE	$125,000	$250,000	$500,000
BUSINESS INCOME LOSS COVERAGE	$100,000	$100,000	$100,000
→ **SELECT AN OPTION:**	☐	☐	☐

59. Is your patient information data encrypted AND do you encrypt sensitive patient data when transmitting it outside of your practice? ..... ☐ Yes ☐ No

60. Are firewalls in place between your network and the public internet? ..... ☐ Yes ☐ No

61. Do you deploy anti-virus, spam and malware defenses on all network workstations? ..... ☐ Yes ☐ No

62. Have you ever experienced an extortion attempt of demand with respect to your computer systems? ..... ☐ Yes ☐ No

63. Are you or any other proposed insured aware of any actual or alleged fact, circumstance, issue, situation, error or omission or even which:

    Might give rise to an obligation to comply with a law requiring notification of an actual or suspected disclosure of personal information? ..... ☐ Yes ☐ No

    Might give rise to a claim against any proposed insured for disclosure, loss or misuse of personal information, invasion or interference with rights of privacy, or which might otherwise result in a claim against any proposed insured with respects to the insurance sought? ..... ☐ Yes ☐ No

If **"Yes"**, please provide details: _____

_____

_____

_____

_____

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FRAUD WARNING

NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, FLORIDA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

NOTICE TO 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.

NOTICE TO 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.

NOTICE TO 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.

NOTICE TO KANSAS APPLICANTS: any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy, or a claim for payment or other benefit pursuant to an insurance policy which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

NOTICE TO 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.

NOTICE TO 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.

NOTICE TO MAINE AND WASHINGTON 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 a denial of insurance benefits.

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

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO 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.

NOTICE TO 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 civil fines and criminal penalties.

NOTICE TO 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.

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

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes 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.

NOTICE TO TENNESSEE AND 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.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

APPLICANT'S REPRESENTATIONS AND AUTHORIZATIONS

On behalf of the group and all potential insureds within the group ("We"), the information in this application is provided after polling all potential insureds and is true, complete and accurate and this information binds all potential insureds within the group. We have no knowledge of any other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's evaluation of risk. We authorize the release of any underwriting and/or claim information from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals, to the carrier and its subsidiaries or agents.

We understand that no coverage will be bound until after the carrier has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of the carrier intent to provide coverage. If coverage is declined by the carrier, any advance payment will be promptly returned.

We understand that should an incident, injury, or death occur, subsequent to signing and dating this application, we will notify Aspen or their authorized broker, in writing, of such event.

We authorize Aspen to release certificates of insurance and claim information to any third party payor, HMO, PPO, hospital or Managed Care Organization.

Signature of Authorized Representative **Date**

NOTICE TO MARYLAND APPLICANTS: IN THE EVENT OF ANY MATERIAL CHANGE, THE INSURER HAS THE ABILITY TO CANCEL A BINDER OR POLICY, OR RECALCULATE THE PREMIUM FROM THE EFFECTIVE DATE OF THE POLICY, DURING THE FORTY FIVE (45) DAY UNDERWRITING PERIOD, IN ACCORDANCE WITH MARYLAND INSURANCE ARTICLE §12-106.

This application is in compliance with Section 626.752, Florida Statutes. A copy has been furnished to the applicant or insured and coverage is: [ ] Bound Effective (time) (date); [ ] Not Bound.

BROKER'S SIGNATURE:

Some states require that we have the Name and Address of your (Applicant's) Authorized Agent or Broker.

Signature of Authorized Agent or Broker: _____

Name of Authorized Agent Broker: _____

Address: _____

License Identification Number: [Florida Applicant's Only] _____

SUPPLEMENTAL CLAIM INFORMATION FORM

Please provide the information below for each additional claim or suit to report.

☐ If you do not have any claims/incidents open or paid, please check the box at the left and sign the bottom.

1. Physician's name (please print): _____
2. Patient's name: _____ Age: _____ Sex: _____
3. Date of first consultation: _____
4. Physical condition and diagnosis at the above date: _____

_____

_____

5. Nature of treatment given and dates of same: _____

_____

_____

6. Date of incident or occurrence from which claim resulted: _____
7. Date of claim: _____
8. Allegations made against you: _____

_____

_____

_____

9. Was this claim reported to your insurance carrier? ..... ☐ Yes ☐ No
   If **"Yes",** list name of carrier and policy number: _____
10. Present status or disposition of claim including amount of settlement or judgment: _____

_____

11. Subsequent condition or health of patient: _____
12. Names of other doctors and hospitals (if any) involved in the claim or suit: _____

_____

_____

_____ _____

Signature of Applicant **Date**

Send E-mail

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