

Washington State Medical Malpractice

*PHYSICIANS & SURGEONS
APPLICATION FOR
PROFESSIONAL LIABILITY INSURANCE*

C L A I M S - M A D E

IMPORTANT

GENERAL INSTRUCTIONS: It is essential that all statements be completed and all questions answered that apply to you or your specialty. If the answer to any question is “No,” be certain to check “No” on the application. DO NOT LEAVE ANY QUESTION UNANSWERED. IF ADDITIONAL SPACE IS REQUIRED, PLEASE USE THE “REMARKS” SECTION AT THE END OF THE APPLICATION. Please print or type your answers. To expedite the processing of your application, please attach the results of your self query of your National Practitioner Data Bank profile, your curriculum vitae, and a current loss run from your current and prior insurer(s).

PRIOR ACTS COVERAGE: If you currently have a Claims-Made policy and want Prior Acts Coverage, the retroactive date is the date you first became insured under a Claims-Made policy. To apply for this coverage, please complete Section III, Prior Acts, of the application.

Prior Acts Coverage does **not** cover claims, suits, incidents or potential claims of which you are, or have reason to be, aware. These matters **must** be reported to your current carrier. You should always request confirmation in writing from that carrier that it will cover claims arising out of these reports.

It is important that you realize that the coverage afforded under Prior Acts Coverage with an insurance carrier that may be selected, if granted, might differ from the coverage afforded by your current carrier. Any claims reported under an insurance carrier that may be selected policy will be subject to the policy terms in effect at the time the claim is reported.

CONFIRMATION OF PROFESSIONAL LIABILITY COVERAGE TO HOSPITALS:
Under question #19 (page 3), you may request that we automatically send a Confirmation of Coverage Statement to the hospitals you list.

SECTION I – APPLICANT INFORMATION

Agent Name/Number (if applicable): _____

Desired Effective Date: _____ Desired Retroactive Date (if applicable): _____

DESIRED LIMITS OF LIABILITY: \$1,000,000/5,000,000 \$2,000,000/6,000,000 \$3,000,000/7,000,000
 \$4,000,000/8,000,000 \$5,000,000/9,000,000

Your practice is: Full-time Part-time, total number of practice hours per week (incl. hospital rounds, charting, patient visits/consults, phone contact) and on call hours involving patient contact: _____

1. Name: _____ 2. DOB: _____ 3. M F
last first middle

4. Principal medical specialty or subspecialty in which you practice: _____

5. SS #: _____ 6. State in which your primary practice is/will be located: _____
License # _____

7. Are you licensed to practice in any other state(s)? Yes No
a. _____ b. _____
state license number state license number

8. Desired policy mailing address: _____
street address city state zip code

9. Home address: _____
street address city state zip code

area code telephone fax Home E-mail address

10. Office practice location(s): Clinic name: _____
a. _____
street address city state zip code

area code telephone Average weekly practice time at this location: Business E-Mail Address

Do you perform surgical procedures at this location? Yes No

If "Yes," list all procedures in the "REMARKS" section.

b. _____
street address city state zip code

area code: _____ telephone: _____ Average weekly practice time at this location: _____

Do you perform surgical procedures at this location? Yes No

If "Yes," list all procedures in the "REMARKS" section.

NOTE: If you have more than two office practice locations, please use the "REMARKS" section.

11. Where have you practiced medicine in the past 10 years? Include military and any public service organizations. PLEASE INCLUDE A CURRICULUM VITAE (CV) WITH YOUR APPLICATION. Please provide evidence of purchase of the Extended Reporting Endorsement Coverage ("Tail") if not requesting Prior Acts. If you have not practiced medicine continuously, please explain/document those time periods in the "REMARKS" section.

a. _____
facility name

_____ street address _____ city _____ state _____ dates

_____ professional liability insurance carrier _____ policy #

b. _____
facility name

_____ street address _____ city _____ state _____ dates

_____ professional liability insurance carrier _____ Policy #

Have you practiced without insurance at any time? Yes No
If "Yes," please explain in the "REMARKS" section.

12. Are you a member of your state medical association? Yes No State: _____ If applying, check here:
Are you a member of any other professional society or association? Yes No
If "Yes," please list. _____

13. Medical School: _____
Name of Medical School

city state/country yr graduated Degree

If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?
 Yes No Have you passed the FLEX? Yes No

14. Residency: _____
name of hospital

_____ street address _____ city _____ state _____ zip

_____ type of residency _____ to _____
dates attended

Was residency completed? Yes No If "No," please explain: _____

15. Additional training (Internship/Fellowship/Second Residency): _____
name of facility (hospital)

_____ street address _____ city _____ state _____ zip

_____ type of training /type of residency _____ to _____
dates attended

Was residency completed? Yes No If "No," please explain: _____

16. Board Certification: _____
name of board _____ date certified _____ Recertified

17. If you are not Board Certified, have you taken and failed board exams? Yes No

Are you Board eligible? Yes No Date eligibility expires: _____ / _____
month year

If not Board Certified and/or Board eligible, please explain in the "REMARKS" section.

SECTION II – CURRENT PRACTICE AND RATING INFORMATION

18. Principal medical specialty or subspecialty in which you practice and for which you are seeking professional liability insurance: _____

19. Hospital privileges:

Primary Hospital:

Secondary Hospital:

_____ name of hospital

_____ name of hospital

_____ city

_____ city

Average number of hours per week at this hospital: _____

Average number of hours per week at this hospital: _____

Category of privileges (active, consulting, courtesy, etc.): _____

Category of privileges (active, consulting, courtesy, etc.): _____

Department of: _____

Department of: _____

Send Confirmation of coverage? Yes No

Send Confirmation of coverage? Yes No

Do you staff the E.R. at this hospital other than to maintain hospital privileges?

Yes No If "Yes,"

number of hours per week: _____

Do you staff the E.R. at this hospital other than to maintain hospital privileges?

Yes No If "Yes,"

number of hours per week: _____

Please list any other hospitals at which you hold privileges: _____

20. If you do not currently have hospital privileges, explain the referral method you use if a patient requires hospital admission: Please explain why you do not maintain hospital privileges.

21. Your practice is (check all that apply):

Individual (solo unincorporated)

Sole shareholder of a medical corporation

Name of corporation: _____

Employee of*: _____

Independent contractor for*: _____

If written contract, please submit a copy.

Partner of a partnership*

Name of partnership: _____

Shareholder of a multi-shareholder corporation*

Name of multi-shareholder corporation: _____

22. Are you a member of a PHO, IPA, MSO, PHCO, IPO, or similar physician organization? Yes No

Name of physician organization: _____

* Please provide names of all physicians or attach a copy of letterhead of the organization.

23. Do you employ other physicians?

Yes No

Please list names in 'REMARKS' section.

24. If you are a **solo practitioner**, indicate the extent of your professional relationship with any physician(s) with whom you are associated:

- | | |
|---|--|
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> Share professional employees |
| <input type="checkbox"/> Share office space only | <input type="checkbox"/> See each other's patients (other than on-call) |
| <input type="checkbox"/> Common billing and/or letterhead | <input type="checkbox"/> Name(s) of physicians with whom you are associated: |

25. How many of the following ancillary personnel do you employ, contract, supervise or sponsor: (if you are a member of a partnership/corporation, this does not apply.)

- | | | |
|---|---------------------------------------|------------------------------------|
| _____ RN/LPN | _____ Nurse Practitioner* | _____ Licensed Surgical Assistant* |
| _____ Lab/X-ray technician | _____ CRNA* | _____ Certified Nurse Midwife* |
| _____ Paramedic* | _____ Registered Physician Assistant* | _____ Licensed Midwife* |
| _____ Alternative Health Care Provider* (Please describe) | _____ | |

***If you employ, contract, supervise, or sponsor any of the above, please describe their relationship and duties in the "REMARKS" section, and attach copies of their credentials.**

26. Do you have a practice activity or position for which you do not require coverage? Yes No
If "Yes," please provide details in the "REMARKS" Section.

27. Do you use an office surgical suite? Yes No

28. Are you associated (**except by medical staff appointment**) with the following:

- | | | |
|---|------------------------------|-----------------------------|
| Health care facility having bed and board accommodations? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Health care foundation, blood bank, or freestanding laboratory? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Medical service facility maintained by an industrial firm? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| State, federal, or local public entity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Urgent Care facility? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| In an administrative capacity for/with PPOs, HMOs, IPAs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

How many hours per week do you spend in the capacity(ies) above? _____

If the answer to any of the above is "Yes," please provide the full legal name and location of the facility(ies) and the department in which you serve: _____

Is insurance coverage provided by the entity or organization for the activities listed above? Yes No

Name of insurance company: _____

NOTE: IF ANY ANSWER TO QUESTIONS 29 THROUGH 37 IS "YES," USE THE "REMARKS" SECTION TO PROVIDE DETAILS. PROVIDING ADEQUATE DETAIL AND DOCUMENTATION WILL ASSIST US IN EXPEDITING OUR UNDERWRITING REVIEW.

29. Has your license to practice medicine or dispense narcotics in any jurisdiction **ever** been limited, denied, revoked, suspended, or voluntarily surrendered or subjected to probationary conditions, or have proceedings towards any of those ends been instituted against you?

- | | | |
|-----------------|------------------------------|-----------------------------|
| Medical License | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DEA License | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

30. Have you been denied membership or renewal thereof or been subject to any disciplinary action in any national, state, or local medical organization, independent practice association, or professional society, or have proceedings towards any of those ends been instituted against you? Yes No

31. Have you **ever** been subject to governmental agency, medical, or professional society disciplinary proceedings resulting in reprimand, censure, sanction, or modification of your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by any such agency or society? Yes No

32. Have you **ever** been convicted for an act committed in violation of any law or ordinance other than traffic offenses?
 Yes No
NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.
33. Have you had an application for membership or privileges at a hospital, health maintenance organization, independent practice association, or other health care facility denied, granted with limitations, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have any such actions been recommended by a standing medical staff committee or governing board of a hospital or other health care facility? Yes No
34. Has your professional liability insurance **ever** been declined, cancelled, refused renewal, or issued on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature?
 Yes No
35. Have you **ever** incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (alcoholism, convulsive disorders, mental illness, multiple sclerosis, narcotics addition, HIV, etc.)? Yes No **If “yes,” in the “REMARKS” section, state illness or disability with date(s), and provide the name of and a statement from your treating physician attesting to your fitness to practice your profession.**
36. Has **any** claim or suit for alleged malpractice **ever** been brought against you or your professional corporation?
 Yes No **If “Yes,” give full details on the Claim Information Supplement, which is attached as part of this application, for ALL claims even if closed for no payment.**
37. Has the threat or avoidance of disciplinary action ever caused you to voluntarily relinquish a medical staff membership, clinical privilege, professional license, or narcotics registration? Yes No **If “Yes,” give full details on the Claim Information Supplement, which is attached as part of this application.**

SECTION III – PRIOR ACTS INFORMATION (to be completed by all applicants requesting Prior Acts Coverage)

NOTE: Include current copy of the declarations page from your current or previous insurer.

Retroactive date: _____

38. Have you been continuously covered by an individual Claims-Made policy for your primary practice from the retroactive date stated on page 1 to the requested effective date of your coverage with the _____ Yes No insurance carrier which may be selected?

If “No,” please explain in the “REMARKS” section.

39. During the period for which you are requesting Prior Acts Coverage, did you practice with other physicians:

- In an employer-employee relationship? Yes No
 Locum tenens relationship? Yes No
 Formal partnership or informal association? Yes No
 Corporation? Yes No

If “Yes,” list the full names of all physicians with whom you have been associated during this period:

40. Indicate below the health care providers you employed, contracted, or supervised during the period for which you are requesting Prior Acts Coverage and please describe the nature of your relationship. If none, please indicate.

Physician Assistant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates	_____
Nurse Practitioner	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates	_____
Nurse Midwife	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates	_____
Nurse Anesthetist	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates	_____
Licensed Surgical Assistant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates	_____

41. Indicate all practice locations during the period for which you are requesting Prior Acts Coverage.

_____	_____	_____
city	state	dates
_____	_____	_____
city	state	dates

42. During the period for which you are requesting Prior Acts Coverage, was your practice different from your practice as described in Section II of this application? For example, did your practice formerly include obstetrical care or emergency medicine services which you are no longer providing? Yes No If “Yes,” describe below the changes in your practice, including all applicable dates. Attach additional pages as needed.

43. Are you aware of the following circumstances that might *reasonably* lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?

- a. Patient or attorney request for records related to an adverse outcome? Yes No
 b. A letter from an attorney regarding your medical treatment of a patient? Yes No
 c. Intra-operative or postoperative complications or other complications resulting in death, paralysis, or other significant disabilities? Yes No
 d. Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes No
 e. A patient who is suing another physician or hospital for the same treatment at issue? Yes No
 f. Any other circumstance that might reasonably lead to a claim or suit? Yes No

Explain any “Yes” answer on the attached Claim Information Supplement.

44. Have you reported to your current insurance company all the above circumstances of which you are aware that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit)?

- Yes Please attach documentation of all such reports.
 No **Please explain in the “REMARKS” section.**
 None to report

SECTION IV – SPECIALTY QUESTIONS

Please be certain to answer all questions applicable to your specialty or procedure. If the answer is "No," be certain to check "No."

ANESTHIOLOGY

1. Do you practice in other than a hospital setting (office surgical suite, surgery center, etc.)? Yes No
2. Please indicate type of anesthesia used outside of hospital setting: _____

3. If yes, is the suite/center certified by the American Association for Accreditation of Ambulatory Surgery Facilities? Yes No
4. Do you practice in the field of pain management? Yes No Acupuncture? Yes No
If "Yes," are you board certified in Pain Management by the American Board of Anesthesia? Yes No
If "Yes" to either of the above, please provide details of practice including methods used, pain-management training, and patient selection criteria: _____
Percent of practice _____ %
Please list procedures and medications you use for pain medication: _____

What types of narcotics do you prescribe for relief of pain? _____
Do you use a dictated record for pain patients? Yes No
5. What portion of your practice consists of the following:
Pediatrics _____ % OB _____ % Cardiac _____ %
Pain Management _____ % Operative Anesthesia _____ % Other _____ %
6. Please indicate the type of monitoring you utilize during the administration of sedation, spinal, caudal, epidural, major nerve blocks or general anesthesia:
 - Continuous electrocardiographic display
 - Continual blood pressure monitoring either by use of an intra-arterial and electronic monitor or by use of standard blood pressure cuff with periodic checks at regular intervals
 - Use of precordial, esophageal, or peritracheal stethoscope
 - Continuous peripheral blood flow monitoring (pulse monitor)
 - Pulse Oximeter
 - End tidal CO₂ monitor
 - Other: _____
7. Do you perform hypotensive anesthesia? Yes No
If yes, in a hospital in a surgery center
8. Do you supervise CRNAs? Yes No
Maximum number of CRNAs you will supervise at any one time: _____
Are the CRNAs you supervise: hospital employees? your own employees? other: _____

EMERGENCY MEDICINE

1. Are you required to supervise emergency medical technicians via radio? Yes No
2. Are you required to perform: Obstetrics/Emergency deliveries
 Surgery
3. Please describe the extent of surgery you perform: _____

GENERAL, CARDIAC, NEUROLOGICAL, THORACIC, UROLOGICAL AND VASCULAR SURGERY

1. Do you perform organ transplants? Yes No If "Yes," what types? _____
2. Do you perform bariatric surgery? Yes No If "Yes," please describe types of procedures performed and patient selection criteria: _____
Percent of practice _____ %
3. Do you subspecialize? Yes No If "Yes," subspecialty: _____
Percent of practice _____ %
4. Do you perform any surgery that is not categorized as part of your specialty? Yes No
If "Yes," please list procedures performed: _____
5. Do you perform endoscopic surgeries (endoscopic, laparoscopic, arthroscopic, etc.?) Yes No
If "Yes," please specify: _____

GENERAL/FAMILY PRACTICE, DERMATOLOGY, RADIOLOGY & OTHER NONSURGICAL SPECIALTIES (Except Pediatrics & Emergency Medicine)

1. Do you assist in surgery on **your own patients only**? Yes No
Do you assist in surgery on **other than your own patients**? Yes No
2. Do you perform induced, non-spontaneous abortions? Yes No
First Trimester, less than 12 weeks _____ (number/month)
Second Trimester, 12-16 weeks _____ (number/month)
Second Trimester, over 16 weeks _____ (number/month)
List hospitals, clinics, or other facilities where performed: _____
3. Do you provide obstetrical care? Yes No
Uncomplicated prenatal care, labor, and delivery? _____ Number of deliveries performed per year: _____
High-risk pregnancies, including but not limited to cesarean section, VBAC, or identifiable prospects of multiple births, preeclampsia, insulin-dependent diabetes, cardiac disease, renal disease, morbid obesity, or other life-threatening conditions? _____ Number of deliveries performed per year: _____
Are deliveries undertaken in other than a licensed hospital (except in an emergency)? Yes No
If "Yes," please explain in "REMARKS" section.

4. Do you ever administer any spinal, caudal, epidural, or general anesthesia? Yes No
5. Do you perform in-office anesthesia? Yes No **If "Yes," please indicate level:** Minimal Sedation
 Moderate Sedation/Analgesia Deep Sedation, Major Conduction Analgesia General Anesthesia
6. Please check surgical procedures and medical techniques you perform:
- | | |
|--|--|
| <input type="checkbox"/> Acupuncture for analgesia _____ % of practice | <input type="checkbox"/> Left Heart Catheterization |
| <input type="checkbox"/> Acupuncture, other: _____
_____ % of practice | <input type="checkbox"/> Liposuction _____ cc of fat removed |
| <input type="checkbox"/> Alternative or Complementary Medicine | <input type="checkbox"/> MOHS technique |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Open Reduction of Fractures |
| <input type="checkbox"/> Appendectomies | <input type="checkbox"/> Other Visualization of Internal Organs |
| <input type="checkbox"/> Body Imaging | <input type="checkbox"/> Pain Management, please describe: _____
_____ |
| <input type="checkbox"/> Chemical Peels (Baker or Phenol) | <input type="checkbox"/> Plastic Surgery Procedures, please describe:
_____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Deep Radiation/X-Ray Therapy
(over 120 k.v.) | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diagnostic Embolization | <input type="checkbox"/> Right Heart Catheterization (other than Swan-Granz) |
| <input type="checkbox"/> Dilatation and Curettage | <input type="checkbox"/> Scalp Reduction |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Shock Therapy |
| Therapeutic _____ # | <input type="checkbox"/> Transluminal Angioplasty |
| Diagnostic _____ # | <input type="checkbox"/> T&As |
| <input type="checkbox"/> Hair Transplants | <input type="checkbox"/> Tubal Ligations |
| <input type="checkbox"/> Hemorrhoidectomies | <input type="checkbox"/> Urgent Care _____ % of practice |
| External _____ # | <input type="checkbox"/> Percent of return patients _____ % |
| Internal _____ # | <input type="checkbox"/> Vasectomies |
| <input type="checkbox"/> Herniorrhaphies | <input type="checkbox"/> Weight Reduction Drugs |
| <input type="checkbox"/> Hysterectomies | Name of medication _____ |
| <input type="checkbox"/> Injection of Radiopaque Dye
(other than IVP, CAT scans, and MRI) | <input type="checkbox"/> Percentage of patients _____ % |
| <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Telemedicine |
| <input type="checkbox"/> Laser Procedures, please describe:

_____ | <input type="checkbox"/> Virtual Medicine |
7. Does your practice include videoscopic surgeries (endoscopic, laparoscopic, arthroscopic, etc.)?
 Yes No
8. If you are **NOT** a radiologist, do you read your own X rays? Yes No If "yes," do you have them over read by a radiologist? Yes No
9. Are you responsible for the primary management of critical care or intensive care patients? Yes No

OBSTETRICS AND GYNECOLOGY

1. Do you limit your practice to Gynecology only? Yes No
If "Yes," are you:
a. obligated to cover for a colleague doing OB? Yes No
b. required to be available for OB consultations and deliveries as a part of your hospital staff privileges?
 Yes No
2. Do you provide obstetrical services? Yes No
If "Yes," please provide: _____ Number of vaginal deliveries per year
_____ Number of cesarean sections per year
3. Do you perform induced, non-spontaneous abortions? Yes No
First Trimester, less than 12 weeks _____ (number/year)
Second Trimester, 12-16 weeks _____ (number/year)
Second Trimester, over 16 weeks _____ (number/year)
4. Do you perform deliveries or abortions in a non-hospital facility? Yes No
If "Yes," please list facility name(s): _____

5. Does your practice include infertility patients? Yes No
If "Yes," please elaborate on this activity and procedures performed: _____

6. Do you follow ACOG guidelines for genetic screening? Yes No If "No," please explain: _____

OPHTHALMOLOGY

1. Do you perform the following procedures?
Laser procedures Yes No _____ (number/month)
Radial Keratotomy* Yes No _____ (number/month)
Keratomeileusis (LASIK)* Yes No _____ (number/month)
Photorefractive Keratectomy* Yes No _____ (number/month)
2. Do you perform any ophthalmologic plastic surgery procedures? Yes No
If "Yes," please specify types(s) of procedures performed: _____

CLAIM INFORMATION (NOTE: Include National Practitioner Data Bank Query)

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

4. Allegation: _____

5. Date of Incident: _____ 6. Date Reported: _____

7. Insurance Carrier: _____
Was a lawsuit filed? Yes No

8. Additional Defendants: _____

9. Location of Occurrence: _____

10. Disposition of Claim: _____

11. Amount of Settlement or Judgment: _____
If claim is still open, reserve amount: _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.

12. Condition and Diagnosis at Time of Incident: _____

13. Dates and Description of Treatment Rendered: _____

14. Condition of Patient Subsequent to Treatment: _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Signature

Date

APPLICANT'S AUTHORIZATION AND RELEASE OF CLAIMS INFORMATION (PLEASE READ CAREFULLY)

I authorize and consent to the release of claims information by an insurance carrier that may be selected and its authorized representatives to my employer or to any clinic of which I am an employee, partner, member, or shareholder. I hereby release an insurance carrier that may be selected and its authorized representatives from any liability for the release of said claims information, provided that such release is done in a good faith belief that the receiving party is my employer or a clinic of which I am an employee, partner, member, or shareholder.

This release shall remain in effect until revoked by me in writing.

APPLICANT'S REPRESENTATION (PLEASE READ CAREFULLY)

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of an insurance carrier that may be selected in considering this application have been omitted. **I agree that this shall be the basis of the policy of insurance requested and that I will notify an insurance carrier that may be selected of any changes contained herein.**

APPLICANT'S AUTHORIZATION AND RELEASE (PLEASE READ CAREFULLY)

I acknowledge as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by an insurance carrier that may be selected or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had a application for staff privileges denied, any state licensing agency, any of my attending or treating physicians, the Washington Physicians Health Program, any prior insurance carriers, prior employers or professional associates and an insurance carrier that may be selected or it duly authorized representatives. I hereby release and discharge the providers of committees from any and all legal liabilities which might otherwise incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by an insurance carrier that may be selected or its duly authorized representatives.

Applicant's Signature

Date

(A photocopy of this Authorization shall be considered as effective and valid as the original.)

I UNDERSTAND THAT SIGNATURE OF THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THIS INSURANCE.

Application checklist:

Before submitting your application, please review this checklist to ensure all necessary information has been provided. Missing information could delay the approval of your application.

Sign and date the application (pages 12 and 13)

Include a copy of your current Curriculum Vitae (CV)

Include a copy of your most recent declarations page if applying for prior acts coverage

Include evidence of Extended Reporting (tail) Coverage if not applying for prior acts coverage (not applicable for new graduates just completing residency programs)

Complete the “**REMARKS**” section for any questions requiring additional details (page 11)

Provide a copy of the results of your self query of the National Practitioner Data Bank profile

Include an insurer-produced summary of your prior claims experience

Complete the appropriate portion of **Section IV – Specialty Questions** relating to your specialty