UNDERWRITERS DIRECT ACCESS

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PRIMEENHANCE

1. General Information Proposed Effective Date: _____

Select: ☐ MD ☐ DO

Applicant's Name: _____ Date of Birth: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: _____ Fax: _____

Website address: _____

Physical Location of Business (if different): _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

_____

Contact Person: _____ Producer's Name: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

_____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other: _____

Type of Practice: ☐ Solo Practice ☐ Small Group (2-4 physicians) ☐ Large Group (5+ physicians)
☐ Multi-specialty Group

Is this a new business? ☐ Yes ☐ No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: _____

_____

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: _____

_____

Annual Payroll: $ _____ Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: _____

_____

_____

2. Insurance History

Who is your current malpractice insurance carrier (or your last if no current provider)? **Please include a copy of the Declarations page of your current policy.**

_____

Provide name(s) for all insurance companies that have provided Applicant malpractice insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Retro Date			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor ever had a professional liability claim? ☐ Yes ☐ No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

3. Other Insurance

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	**2**	**3**
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	$	$	$

4. Desired Insurance

Per Covered Person/Aggregate

☐ $15,000/$60,000
☐ $25,000/$100,000

How did you hear about PrimeEnhance?

☐ Internet

☐ Broker

☐ PrimeEnhance Representative

☐ Fellow Physician: Please list name: _____

☐ Direct Mail Advertisement

☐ Conference: Please list conference: _____

☐ Other: _____

5. Business Activities

THE FOLLOWING MUST BE INCLUDED WITH THIS APPLICATION:

☐ Copy of your current professional liability insurance Declarations Page and currently valued loss experience.

☐ Copy of your Curriculum Vitae.

☐ Copies of all advertising that you use, including Yellow Page ads.

☐ Copy of your business letterhead.

☐ Supplementary Applications, Claim Information Supplement(s) and additional documentation as needed.

Medical Training and Practice History

1. Medical Specialty: Percent of Practice:_____%		2. Medical Sub-Specialty: Percent of Practice:_____%		
	Hospital / College	City & State	Completed?	Year
Medical School			☐ Yes ☐ No	
Internship			☐ Yes ☐ No	
Residency			☐ Yes ☐ No	
Additional Residency			☐ Yes ☐ No	
Fellowship			☐ Yes ☐ No	

1. Are you a U.S. citizen? ☐ Yes ☐ No
   If NO, please provide a copy of documents confirming your status.
2. Are you a Foreign Medical School Graduate? ☐ Yes ☐ No
   Date of ECFMG certification:_____
3. Are you currently Board Certified? ☐ Yes ☐ No
   Name of Board:_____
   Date Certified/Re-certified: _____
   If no, are you Board Eligible? ☐ Yes ☐ No
   Name of Board: _____
   Status: _____ Est. Date of Certification: _____
4. Date you began practicing: _____. Within the last five years have your practice characteristics, procedures performed, or business association(s) changed? ☐ Yes ☐ No
   If YES, please describe details of change on additional sheet.

5. Please list the names of all physicians that perform aesthetic procedures in your practice: (attach additional sheets as necessary)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

6. List all primary office locations where you have practiced in the last 10 years. (Use separate sheet if more space is needed).

Street Address & City State Dates – From / To

_____

_____

_____

_____

7. Please list below all hospitals where you have staff privileges. (*If no hospital privileges, attach protocol for patient admission*).

HOSPITAL	CITY/ STATE	COUNTY	% OF PRACTICE

8. List the following information for each state where you practice:

STATE	MEDICAL LICENSE NUMBER(S):	DEA LICENSE NUMBER(S):	% OF PRACTICE IN EACH STATE:	STATUS OF LICENSE
			%	
			%	
			%	
			%	

9. Please indicate the number of CME hours you have obtained in the past two years: _____

10. Indicate your gross annual receipts for the following:

Major Surgery	$
Minor Surgery	$
Office Visits	$
Obstetrics/Gynecology	$
Cosmetic Surgery	$
Other (specify):_____	$

TOTAL:	$

11. Identify the percentage of your business operations which are:

Performed by you	%
Performed by your staff	%
Other (specify): _____	%

12. Estimate total gross receipts from all operations for the next 12 months:

Major Surgery	$
Minor Surgery	$
Office Visits	$
Obstetrics/Gynecology	$
Cosmetic Surgery	$
Other (specify):_____	$
TOTAL:	$

13. Estimate total annual gross receipts from all business operations for the next 12 months:

    $_____

14. Please indicate, on the following list, the anticipated number of elective (*not* medically necessary or reconstructive) procedures that will be done in the coming 12 months:

Non-surgical elective procedures:

Botox _____	Chemical Peels _____	Dermabrasion _____	Laser Skin Resurfacing _____	Microderma-brasion _____	Sclerotherapy _____	Skin Rejunvenation _____	Soft Tissue Augmentation _____
Please indicate where these procedures were performed in the last 12 months: Hospital: _____% Accredited Surgery Center: _____% Office: _____% Other: _____%							
PrimeEnhance Class A Procedures, all done under local anesthesia only:							
Cosmetic Dentistry _____	Cosmetic Gum Surgery _____	Dental Implants _____	Dental Veneers _____	G-Spot Enhancement _____	Laser Eye Surgery _____		
Please indicate where these procedures were performed in the last 12 months: Hospital: _____% Accredited Surgery Center: _____% Office: _____% Other: _____%							
PrimeEnhance Class B Procedures, all done under local anesthesia, with or without oral sedative:							
Abdominoplasty _____	Autologous Fat Transfer _____	Blepharoplasty _____	Breast Augmentation _____	Cheek Implants _____	Chin Augmentation _____	Facial Implants _____	Forehead Lift _____
Gynecomastia _____	Labiaplasty _____	Liposuction _____	Lower Body Lift _____	Neck Lift _____	Otoplasty _____	Pectoral Enlargement _____	Rhinoplasty _____
Thigh Lift _____	Thighplasty _____	Upper Arm Lift _____	Vaginoplasty _____				
Please indicate where these procedures were performed in the last 12 months: Hospital: _____% Accredited Surgery Center: _____% Office: _____% Other: _____%							
PrimeEnhance Class C Procedures, all done under general anesthesia or iv anesthesia:							
Autologous Fat Transfer _____	Blepharoplasty _____	Breast Lift _____	Breast Reduction _____	Brow Lift _____	Buttock Augmentation _____	Buttock Lift _____	Cheek Implants _____
Chin Augmentation _____	Facial Implants _____	Forehead Lift _____	Gynecomastia _____	Labiaplasty _____	Neck Lift _____	Otoplasty _____	Petoral Enlargement _____
Rhinoplasty _____	Thighplasty _____	Upper Arm Lift _____	Vaginoplasty _____				
Please indicate where these procedures were performed in the last 12 months: Hospital: _____% Accredited Surgery Center: _____% Office: _____% Other: _____%							

PrimeEnhance Class D Procedures, all done under general anesthesia or iv anesthesia:						
Abdominoplasty _____	Breast Augmentation _____	Face Lift _____	Liposuction _____	Lower Body Lift _____	Thigh Lift _____	
Please indicate where these procedures were performed in the last 12 months: Hospital: _____% Accredited Surgery Center: _____% Office: _____% Other: _____%						
PrimeEnhance Class E Procedures, all done under general anesthesia or iv anesthesia: Any Class C or class D procedures with abdominoplasty on same day _____						
Please indicate where these procedures were performed in the last 12 months: Hospital: _____% Accredited Surgery Center: _____% Office: _____% Other: _____%						

15. Please list all hospitals, accredited surgery centers and offices where above procedures were performed in the last 12 months. For non-accredited facilities, please attach the most recent state inspection report.

Facility Name and Location:	Accreditation:	Contact Name & Telephone:

6. Office Staff

1. Do you employ, contract with, or supervise any physician(s) or surgeon(s)? ☐ Yes ☐ No
   If YES, advise of number and attach current certificate(s) of insurance.
2. Do you employ, contract with or supervise any non-physician health care extenders? ☐ Yes ☐ No
   If YES, enter information below:

	NUMBER		**NUMBER**
LPN		Certified Nurse Midwife (CNM)	
RN		Pharmacist	
CNA		Laboratory Technician	
Physician Assistant:		Other (please describe):	

7. Practice Information

1. Please indicate:
   a. Average number of patients seen each week: _____
   b. Average number of patients seen each month: _____
   c. Average number of patients seen each year: _____
   d. Percentage of locum tenens work: _____%
2. Weekly practice hours: _____ to _____

3. Please list any medical association membership(s): _____

_____

4. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center? ☐ Yes ☐ No
   If YES, please describe on separate sheet.
5. Do you perform abortions? ☐ Yes ☐ No

   If YES, please tell us:

   a. Indicate number each month: _____ Type: ☐ Elective ☐ Therapeutic

   b. Where performed? (Check all that apply) ☐ Office ☐ Hospital ☐ Other (Explain on separate sheet).

   c. Maximum Gestation Age? _____

6. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? ☐ Yes ☐ No
   If YES, please describe on separate sheet.
7. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ Yes ☐ No
   If YES, please describe on separate sheet.
8. Are you now, or have you ever been involved in any professional liability claim or suit? ☐ Yes ☐ No
9. Are you aware of any circumstances that might lead to a claim or suit? ☐ Yes ☐ No

   If YES, has this information been reported to a current or prior insurance carrier? ☐ Yes ☐ No

10. Has your professional liability insurance ever been refused, cancelled, or non-renewed? ☐ Yes ☐ No
    If YES, please explain on a separate sheet. (*Response not required in the state of Missouri*).
11. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
12. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? ☐ Yes ☐ No
13. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
14. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s), or a state licensing authority? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
15. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
16. Do you now or have you ever treated prisoners in a state, federal, or any correctional institution? ☐ Yes ☐ No

    If yes, provide details: _____

    _____

17. Do you authorize any collection agency, at its own discretion, to file a claim or suit? ☐ Yes ☐ No
18. Do you work in an Emergency Room for other than maintaining hospital privileges? ☐ Yes ☐ No
    Please indicate the average number of hours you work in the Emergency Room each month:
19. Are you a sports team physician or health care provider? ☐ Yes ☐ No
    If YES, check all that apply: ☐ High School ☐ College ☐ Professional ☐ Other

    Name and location of teams: _____

20. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director, or are you under contract to provide professional services, at any Nursing Home or similar facility? ☐ Yes ☐ No

    If YES, describe percentage of your practice and name(s) of nursing home facilities: _____

    _____

21. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director of a hospital or hospital department, sanitarium, ambulatory care clinic with bed and board facilities, health maintenance organization, preferred provider organization, or any other business enterprise? ☐ Yes ☐ No

    If YES, please identify, provide address, and explain details on a separate sheet.

22. Do you serve in a 'Gatekeeper' capacity—that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization? ☐ Yes ☐ No

    If YES, please advise of percentage of your practice devoted to Gatekeeper activity: _____%

23. Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)? ☐ Yes ☐ No
    If YES, please describe on separate sheet.

8. Anesthesia / Office Surgery

1. Do you perform or assist in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis? ☐ Yes ☐ No
   If YES, please complete the questions below:

   a. Description and annual number of procedures: _____

      _____

   b. Annual number of procedures with: General Anesthesia: _____

      Spinal or Caudal Anesthesia: _____

      Other: _____ Describe: _____

   c. Anesthesia administered by: _____

   d. Distance to nearest hospital: _____

   e. Description of life-saving equipment/supplies: _____

      _____

      _____

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
PHYSICIANS AND SURGEONS CLAIMS-MADE COVERAGE
ADDITIONAL INFORMATION FORM

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheets if necessary.

QUESTION #	COMMENTS

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name