SHAND MORAHAN & COMPANY, INC.
MARKEL®
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

APPLICATION FOR PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: _____

   (ii) Professional Degree: _____

   (b) Principal practice address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) Secondary practice locations: _____

   _____

   _____

   (d) (i) Phone: _____ (ii) Fax: _____

   (iii) E-Mail Address: _____ (iv) Website Address: _____

   (e) (i) Date of Birth (MM/DD/YYYY): _____ (ii) Place of Birth: _____

   (e) (i) Social Security No.: _____ (ii) Federal Tax ID Number: _____

2. Are you a U.S. citizen? ..... [ ] Yes [ ] No
   If No, what is your status in the U.S. and current citizenship? _____

3. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)*
   [ ] professional corporation* [ ] professional association*
   [ ] limited liability company* [ ] partnership*
   [ ] employee of _____ [ ] independent contractor of _____
   [ ] other _____
   * Specify name of entity: _____

   (b) Do you want coverage for the entity named Item 3(a) above? ..... [ ] Yes [ ] No

   (c) Attach a copy of your letterhead.

   (d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all physicians practicing under the entity name in Item 3(a)above.

   _____

   _____

4. Do you practice with any physician not named in Item 3.(d) above? ..... [ ] Yes [ ] No
   If Yes, provide the name of each physician and the practice relationship. _____

   _____

5. Are you currently in active military service?..... [ ] Yes [ ] No

6. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

7. Federal DEA License No. and status: _____

8. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

Name	City	State	Percentage of Work	Type of Privileges

9. Are you currently a hospital chief of staff or head of any hospital department? ..... [ ] Yes [ ] No
If Yes, describe. _____

10. Do you or the entity firm named in Item 3(a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgicenter, urgent care center other facility where medical services are customarily provided? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation specifically including the name, location, size, and number of beds. _____

11. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No
If Yes,
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No
(ii) Provide the name and title of the Applicant's Privacy Officer. _____
Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

II. EDUCATION AND TRAINING

1. (a) Provide your medical or surgical specialty: _____
(b) Do you limit your practice to the specialty stated in item (a) above? ..... [ ] Yes [ ] No
(c) Do you have a subspecialty? ..... [ ] Yes [ ] No
If Yes, describe. _____

2. Are you American Board certified? ..... [ ] Yes [ ] No
If Yes, provide the following: Medical specialty in which you are certified: _____
Date of certification: _____ Any recertification date(s): _____
If No, do you plan on taking the Board examination? ..... [ ] Yes [ ] No

3. Provide the following information:

	Name of Institution	City	State	Date Completed
Medical School				
PGY-1/Internship				
Residency – Specialty: _____				
Residency – Specialty: _____				
Fellowship – Specialty: _____				
Other: _____				

4. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? ..... [ ] Yes [ ] No
If Yes, provide the following: year of certification: _____ describe your medical degree: _____

5. Provide a detailed summary of where you have practiced your profession since completing your training:

_____

_____

6. Are you a member of any professional societies? ..... [ ] Yes [ ] No
If Yes, provide information regarding your membership(s). _____

7. How many hours of continuing medical education have you take within each of the last two (2) years? _____

III. SCOPE OF PRACTICE

1. (a) Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia?..... [ ] Yes [ ] No
If Yes, complete 1.(b) below.

(b) If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: **H** = Hospital **O** = Office **S** = Surgi-center of other

	Location		Location
___ Abortions - 1st Trimester	_____	___ Hysterectomies	_____
___ Abortions - 2nd/3rd Trimester	_____	___ Laser skin resurfacing	_____
___ Acupuncture	_____	___ Laser Surgery (describe)_____	_____
___ Adenoidectomy/Tonsillectomy	_____	___ Lymphangiography	
Anesthesia – Non-obstetrical:		___ Minimally invasive surgery (describe)	_____
___ General	_____	_____	_____
___ Spinal	_____	___ Moh's micrographic surgery	_____
___ Epidural	_____	___ Myelography	_____
Anesthesia – Obstetrical:		___ Needle biopsies (describe)_____	_____
___ General	_____	Obstetrics:	
___ Spinal	_____	___ Prenatal care	_____
___ Epidural	_____	___ Normal deliveries - annual no.____	_____
___ Anesthesia – Other (describe)		___ Caesarean sections - annual no.___	_____
_____	_____	___ VBAC deliveries – annual no._____	_____
___ Angiography	_____	___ Open Reduction of Fractures	_____
___ Angioplasty	_____	___ Pain Management (describe)	
___ Anti-aging procedures – other than use of human growth hormone (describe)_____	_____	_____	_____
		Plastic – Cosmetic Procedures:	
___ Arteriography	_____	___ Blepharoplasty	_____
___ Assisting in Surgery – on own patients or the patients of others	_____	___ Collagen injections	_____
		___ Botox injections	_____
___ Breast Implants	_____	___ Liposuction under 3500 cc's volume	_____
___ Breast Reductions	_____	___ Liposuction 3500 cc's or more volume	_____
___ Catheterization - other than umbilical cord, urethral or arterial line in a peripheral vessel	_____	___ Phalloplasty or penile implant	_____
		___ Rhinoplasty	_____
		___ Silicone implants	_____
		___ Silicone injections	_____
___ Cosmetic implantation or injection of silicone or other material	_____	___ Other plastic – cosmetic procedures (describe) _____	_____
___ Cryosurgery - other than on benign or pre-malignant dermatological lesions	_____	___ Pneumoencephalography	_____
		___ Prolotherapy/proliterative therapy	_____
		___ Radiation Therapy	_____
___ Chelation Therapy	_____	___ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	_____
___ Dermabrasion/Chemical Peels	_____		
___ Dilation & Curettage	_____		
___ Discograms	_____	___ Refractive surgery: LASIK, PRK, AK, PTK, ICR	_____
___ Electroconvulsive Therapy	_____		
___ Endoscopic procedures	_____	___ Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy)	_____
___ Hair Transplants or Suturing of Hairpieces	_____	___ Trans Myocardial Laser procedures	_____
___ Hyperbaric Medicine	_____		

2. (a) Do you perform surgery for obesity? ..... [ ] Yes [ ] No
If Yes, complete 2.(b) below.

(b) If you perform any of the following procedures, check all that apply and provide the number of procedures performed:

Roux-en-Y:

___ Laparoscopic:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____

___ Open:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____

Banding:

___ Laparoscopic:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____

___ Open:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____

Gastric Restriction, Other (describe) _____:
No. performed in past 12 months: _____
No. you expect to perform in next 12 months: _____

3. Is general anesthesia administered for any of the procedures identified in 1.(b) or 2. above? ..... [ ] Yes [ ] No
If Yes, is anesthesia is administered by:

(a) you? ..... [ ] Yes [ ] No

(b) an Anesthesiologist? ..... [ ] Yes [ ] No

(c) a Certified Registered Nurse Anesthetist (CRNA)? ..... [ ] Yes [ ] No

If Yes, is the CRNA directed by or responsible to an Anesthesiologist? ..... [ ] Yes [ ] No

If No, explain the type of surgery and percentage of your surgeries or average number of such cases per month.

_____

(d) Are Harvard Standards for the administration of all anesthesia adhered to? ..... [ ] Yes [ ] No

4. (a) Do you perform any surgery in your office? ..... [ ] Yes [ ] No
If Yes, answer the following:

(i) Describe each procedure not already identified above in 1(b) or 2 above: _____

_____

(ii) Is your surgical suite certified? ..... [ ] Yes [ ] No

If Yes, provide the name of the certification body. _____

(b) Do you perform any surgery in other non-hospital facilities? ..... [ ] Yes [ ] No
If Yes, answer the following:

(i) Describe each procedure not already identified above in 1(b) or 2 above: _____

_____

(ii) Name each facility: _____

_____

5. With the exception of surgery for obesity, does your practice include weight reduction or control by other than diet or exercise? ..... [ ] Yes [ ] No

If Yes, answer the following:

(a) Percentage of your patients that are weight control patients: _____

(b) Do you dispense any drugs? ..... [ ] Yes [ ] No
If Yes, provide the name(s) of the drug(s) dispensed. _____

(c) Do you use injections for weight control? ..... [ ] Yes [ ] No
If Yes, provide the name(s) of the drugs injected. _____

6. Do you perform any hospital emergency room care? ..... [ ] Yes [ ] No

If Yes, is this solely a requirement for active admitting privileges? ..... [ ] Yes [ ] No

If No, provide a detailed description including the approximate number of hours per month spent in emergency room care. _____

_____

7. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? ..... [ ] Yes [ ] No
If Yes, provide the following:

(a) Identify all states in which such patients reside: _____

(b) What percentage of your total practice is involved in such activities? _____

8. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? ..... [ ] Yes [ ] No

If Yes, identify all states in which such patients reside. _____

9. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? ..... [ ] Yes [ ] No
If Yes, do you follow FDA-approved protocols? ..... [ ] Yes [ ] No

If Yes, describe. _____

_____

(b) Are you a Principal Investigator for any clinical trial? ..... [ ] Yes [ ] No

10. (a) Indicate the number of professional employees in your practice for each of the following: (If none, check here [ ])

___ Physicians other than yourself ___ Podiatrists ___ Chiropractors ___ Optometrists

___ Physician's Assistants* ___ Nurses ___ Nurse Practitioners* ___ Nurse Anesthetists*

___ Surgeon's Assistants* ___ Nurse Midwives* ___ Psychologists

___ Other (describe) _____

*Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ..... [ ] Yes [ ] No
If No, provide a detailed explanation on a separate page.

11. (a) Average weekly patient load: _____ (b) Number of patients annually: _____

12. Average number of hours you practice each week: _____

13. What is your approximate gross annual income from your practice? (Check one.)

_____ Less than $50,000 ___ $50,000 to $99,999

_____ $100,000 to $149,999 ___ $150,000 to $199,999

_____ $200,000 to $499,999 ___ $500,000 or more (estimate) $_____

14. Do you supervise anyone other than your own employees? ..... [ ] Yes [ ] No
If Yes, indicate by profession the number of individuals you supervise:

___ Physicians other than yourself ___ Podiatrists ___ Chiropractors ___ Optometrists

___ Physician's Assistants ___ Nurses ___ Nurse Practitioners ___ Nurse Anesthetists

___ Surgeon's Assistants ___ Nurse Midwives ___ Psychologists

___ Radiology Technicians ___ Laboratory Technicians ___ Other (describe) _____

Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. _____

_____

15. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

16. Do you currently participate in any state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? ..... [ ] Yes [ ] No

17. Do you anticipate any changes in your practice in the next year? ..... [ ] Yes [ ] No
If Yes, attach a detailed explanation.

IV. AFFILIATIONS

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section I. 3(a) above? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section I. 3(a) above? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

If Yes, does any contract contain a hold harmless agreement? ..... [ ] Yes [ ] No
If Yes, attach a copy of the contract.

3. Are you in the employ of or under contract to any governmental entity? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

4. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? ..... [ ] Yes [ ] No
If Yes, attach a copy of all advertisements.

5. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? ..... [ ] Yes [ ] No
If Yes, attach a copy of the advertisement or applicable website address.

6. Are you the Medical Director of a nursing home, clinic, commercial enterprise or any other organization? ..... [ ] Yes [ ] No
If Yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position. _____

7. Do you have any administrative or teaching responsibilities? ..... [ ] Yes [ ] No
If Yes, provide the following and attach a copy of any contract or agreement:

   (a) Name of entity and location: _____
   Your title _____

   (b) Does the entity provide you coverage for:
      (i) Your administrative responsibilities? ..... [ ] Yes [ ] No
      (ii) Your direct patient care? ..... [ ] Yes [ ] No

8. Do you work for any locum tenens companies? ..... [ ] Yes [ ] No
If Yes, provide the following :

(a) Name of each company that places you in locum positions: _____

(b) Are you an [ ] Employee or [ ] Independent Contractor?

(c) Number of hours each month in which you work in locum positions: _____

(d) Does each company provide you with Professional Liability Insurance for locum positions?..... [ ] Yes [ ] No

If Yes, attach a copy of your Certificates of Insurance.

9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location? ..... [ ] Yes [ ] No
If Yes, provide details. _____

10. Are you engaged in or planning to engage in any "moonlighting" activities? ..... [ ] Yes [ ] No
If Yes, do you want coverage for your "moonlighting" activities? ..... [ ] Yes [ ] No
If Yes, describe the activities. _____

V. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance?..... [ ] Yes [ ] No
If Yes, how many? _____Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? ..... [ ] Yes [ ] No
If Yes, how many? _____Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.

3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?.. [ ] Yes [ ] No
If Yes, how many? _____ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.

4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges?..... [ ] Yes [ ] No

5. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?..... [ ] Yes [ ] No

6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? ..... [ ] Yes [ ] No

7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? ..... [ ] Yes [ ] No

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders?..... [ ] Yes [ ] No

9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty?..... [ ] Yes [ ] No

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

Shand Morahan & Company, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which Shand Morahan & Company, Inc. receives notice is on file with Shand Morahan & Company, Inc. and is considered physically attached to and part of the of the policy if issued. Shand Morahan & Company, Inc. and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Shand Morahan & Company, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc. or the Company, Ten Parkway North, Deerfield, Illinois 60015.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant	Title
Signature of Applicant	Date

Notice to Applicants: 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 information or conceals for the purpose 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.

ADDITIONAL EXPLANATIONS

MARKEL®
SHAND MORAHAN & COMPANY, INC.
Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: