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 PROFESSIONAL LIABILITY INSURANCE FOR ANESTHESIOLOGISTS
(CLAIMS MADE BASIS)

APPLICANT'S INSTRUCTIONS:

1. If you have a Curriculum Vitae, please attach to application and you do NOT have to complete Sections 7-9.
2. Please type or print your answers.
3. If space is insufficient to answer any questions fully, attach separate sheet.
4. Application must be signed and dated on Page 5.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. (i) Full name of Individual Applicant: (include professional degree)

_____ Degree _____

(ii) Date of Birth _____ Place of Birth _____

(iii) Are you a U.S. citizen? [ ] Yes [ ] No.
If "No", please indicate your status and date of entry into USA: _____

b. (i) Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

Phone: (___) _____

(ii) Other Office address: _____

c. Your practice:
___ Solo Practitioner (unincorporated)
___ Solo Practitioner (incorporated)
___ Employee of _____ (Name)
___ Professional Association
___ Partnership
___ Professional Corporation
___ Other (Describe) _____

d. Number of Employees: Full time _____ Part time _____ Total _____

e. If you practice other than as an employee OR an unincorporated solo practitioner:

(i) List the names of ALL your partners, employees and members of your professional association/corporation who practice medicine:

_____

_____

(ii) Formal corporate, association, partnership or business name: _____

(iii) Please attach a copy of your letterhead.

f. (i) Limits of Liability desired: $ _____ each claim $_____ aggregate
(Limits in policy will govern coverage)

g. 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.

2. APPLICANT PRACTICE

a. Please list all states where you are licensed to practice: i. _____ Permanent _____ Temporary

ii. _____ Permanent _____ Temporary

b. (i) Please list hospitals at which you are currently a staff member and show % of work at each hospital.

1. _____ _____%

2. _____ _____%

3. _____ _____%

(ii) Are you chief or head of the department? [ ] Yes [ ] No If "Yes," indicate location #: _____

(iii) Please give the approximate percentages of your practice dedicated to the following specialties. Where applicable, indicate the split between general and local anesthesia.

		General	Local			General	Local
Pediatric	_____%	_____	_____	Intensive Care Mgmt.	____%	_____	_____
OB	_____%	_____	_____	Neuro	____%	_____	_____
Vascular	_____%	_____	_____	Blocks/Epidurals	____%	_____	_____
Open Heart	_____%	_____	_____	Neuro	____%	_____	_____

c. Do you practice in a surgicenter or other non-hospital facility where general anesthesia is administered? ..... [ ] Yes [ ] No
If "Yes", please provide details:

_____

d. Do you limit your practice to anesthesiology? ..... [ ] Yes [ ] No
If "No," indicate your other specialty and provide details:

_____

e. (i) Average patient load: _____ Pts. Weekly _____ Total Pts. Annually

(ii) Average number of hours practice time: _____ Hrs. Weekly

3. APPLICANT PROCEDURES

a. Do you perform acupuncture anesthesia? ..... [ ] Yes [ ] No

If "yes," please provide details: _____

b. During all anesthesia, do you use a pulse oximeter monitor? ..... [ ] Yes [ ] No

If "No," please explain: _____

c. During all anesthetics:

(i) Is an electrocardiogram continuously displayed? ..... [ ] Yes [ ] No

If "No," please explain: _____

(ii) How often is arterial blood pressure determined and evaluated? Every _____ Minutes.

(iii) How often is heart rate determined and evaluated? Every _____ Minutes.

(iv) How is circulatory function evaluated? _____

d. During all general anesthesia, do you use an end tidal CO2 monitor? ..... [ ] Yes [ ] No

If "No," please explain: _____

e. During all general anesthesia using an anesthesia machine, do you:

(i) Use an oxygen analyzer with a low concentration limit alarm? ..... [ ] Yes [ ] No

If "No," please explain: _____

(ii) Test proper functioning alarm prior to each use? ..... [ ] Yes [ ] No

If "No," please explain: _____

f. When ventilation is controlled by a mechanical ventilator, do you

(i) Use a device equipped with a full set of safety alarms? ..... [ ] Yes [ ] No

If "No," explain: _____

(ii) Test proper functioning alarms prior to each use? ..... [ ] Yes [ ] No

If "No," explain: _____

g. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? ..... [ ] Yes [ ] No

If "No," please explain: _____

4. PERSONNEL

a. (i) List number and type of professional employees: (If none, state NONE.)

_____ Physicians (other than yourself) _____ Nurse Anesthetists _____ Other (describe)

(ii) Are all the above individuals licensed in accordance with applicable state and federal regulations? ..... [ ] Yes [ ] No

If "No," please explain. _____

b. Do you supervise any individuals who are not your own employees? ..... [ ] Yes [ ] No

If "Yes," please provide details and number of non-employed individuals supervised:

_____

_____ Physicians (other than yourself) _____ Nurse Anesthetists _____ Other (describe)

5. APPLICANT HISTORY ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

a. Have you or any of the employees, as shown in 4a. above:

		YES	NO
(i) Ever been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	(i)	[ ]	[ ]
(ii) Ever been convicted of an act committed in violation of any law or ordinance other than traffic offense?	(ii)	[ ]	[ ]
(iii) Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment?	(iii)	[ ]	[ ]
(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	(iv)	[ ]	[ ]
(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their professional liability insurance?	(v)	[ ]	[ ]
(vi) Ever failed any medical licensing or specialty organization examination?	(vi)	[ ]	[ ]
(vii) Do you have any chronic physical illness or defect?	(vii)	[ ]	[ ]

b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Insurance Carrier	Limits of Liability	Inception Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]

c. If prior professional liability insurance was on a claims made basis, indicate retroactive exclusion date of coverage. _____

6. CLAIMS

a. Has any claim or suit for alleged malpractice been brought against you? If "Yes," please complete Supplemental Claim Information form for each claim or suit..... [ ] Yes [ ] No

b. Has any judgment been rendered against you or any monetary settlement made by you, or on your behalf by any insurance carrier, from an incident alleging malpractice? If "yes," please complete Supplemental Claim form for each incident. ..... [ ] Yes [ ] No

c. Are you aware of any acts, errors, or omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?..... [ ] Yes [ ] No
If "yes," please complete Supplemental Claim Information form.

7. EDUCATION

a. From what medical school did you graduate? _____

Degree: _____ Year: _____ Location of School: _____
(City) (State) (Country)

b. If foreign medical student graduate, are you certified by Educational Council for Medical School Graduates? ..... [ ] Yes [ ] No

If "Yes," state year and describe: _____

c. Have you had any additional Medical Training? [ ] Yes [ ] No If "Yes," complete the following:

Location _____ From _____ To _____

Type _____

d. Are you American Board certified? [ ] Yes [ ] No Specialty: _____

If not, are you working toward Board Certification? For how long? _____

8. EXPERIENCE

Where have you practiced your profession since completion of training (include all "moonlighting" while in residence/fellowship, military or any public service organization):

a. Prior Experience - From _____ To _____ Location: _____

Practice Activity: _____

b. Prior Experience - From _____ To _____ Location: _____

Practice Activity: _____

c. Prior Experience - From _____ To _____ Location: _____

Practice Activity: _____

9. PROFESSIONAL SOCIETIES

Indicate membership in professional societies:

a. American Board in Medical Specialties: Prior Experience - From _____ To _____ Location: .....

Practice Activity: _____

b. Special Medical Societies: _____

c. Specialty Colleges: _____

d. County Medical and Others: _____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, 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 extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, 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 of insurance and deemed incorporated therein, should the Insurer 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., Ten Parkway North, Deerfield, Illinois 60015**.

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

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: