OneBeacon
PROFESSIONAL INSURANCE®

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Homeland Insurance Company of New York | Homeland Insurance Company of Delaware
(Stock companies owned by the OneBeacon Insurance Group)
(hereinafter referred to as the "Underwriter")

Application

INDIVIDUAL PHYSICIAN

PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDE CLAIMS MADE AND REPORTED COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR AN APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. READ THE POLICY AND THIS APPLICATION CAREFULLY AND CONTACT YOUR PRODUCER WITH ANY QUESTIONS.

For the purposes of this Application, "Applicant Entity" means the entity identified as the "Applicant" in the primary application submitted for this insurance to which a policy may be/has been issued.

Instructions:

The physician identified in question 2 below must attach a copy of his/her curriculum vitae (CV) with this Application.

A. ACCOUNT INFORMATION

1. Applicant Entity:

B. PHYSICIAN INFORMATION

2. Physician Name:

3. List all states where you are licensed to practice and the applicable license number:

State/License Number: _____ State/License Number: _____

State/License Number: _____ State/License Number: _____

4. List all hospitals/facilities where you have staff privileges:

Facility Name, City/State: _____

Facility Name, City/State: _____

5. Please provide the following information regarding your medical education and training:

a. Medical School

Name of school: _____ City: _____ State: _____

Year graduated: _____ Degree: _____

b. Internship

Name of school: _____ City: _____ State: _____

From: _____ To: _____

c. Residency

Name of hospital: _____ City: _____ State: _____

Year completed: _____ Specialty: _____

6. Are you a foreign medical school graduate? ☐ Yes ☐ No

If "Yes," please provide all information pertinent to your ECFMG certification: _____

C. MEDICAL SPECIALTY

7. Primary specialty: _____ Practice %: _____

Sub-specialty: _____ Practice %: _____

8. Are you board eligible or board certified? ☐ Yes ☐ No

If "Yes," please provide the name of the board, the date of certification and the expiration date of certification:

If "No," please explain:

9. Please indicate below the procedures you expect to perform, or in which you will participate in, within the next year, beginning with the date of your requested coverage:

Anesthesia – Pain Management Procedures

- ☐ Acupuncture
- ☐ Cordotomy
- ☐ Dorsal Root Gangliotomy
- ☐ Facet Blocks
- ☐ Infusion Pump Implantation and Removal
- ☐ Intervertebral Procedures
- ☐ Lumbar Sympathetic Block
- ☐ Medication Only
- ☐ Nerve Root Blocks
- ☐ Sphenopalatine Lesioning
- ☐ Spinal Injections
- ☐ Sympathetic Nerve Blocks
- ☐ Thoracic Sympathectomy
- ☐ Trigeminal Lesioning
- ☐ Vertebral Interventions (Vertebroplasty/Kyphoplasty)
- ☐ Other: _____

Dermatology Procedures

- ☐ Blepharoplasty
- ☐ Botox Injections
- ☐ Breast Augmentation
- ☐ Chemabrasion
- ☐ Chemical Peels
- ☐ Collagen Injections
- ☐ Cryosurgery
- ☐ Dermabrasion
- ☐ Elective Plastic Surgery
- ☐ Eye Liner Pigmentation
- ☐ Fat Transfer
- ☐ Hair Transplant
- ☐ Laser Hair Removal
- ☐ Laser Skin Resurfacing
- ☐ Liposuction
- ☐ Tumescent Liposuction
- ☐ Mesotheraphy
- ☐ Microdermabrasion
- ☐ Sclerotherapy
- ☐ Silicone Injection
- ☐ Tattoo Removal
- ☐ Other: _____

Radiology Procedures

- ☐ Fluoroscopic
- ☐ Interventional Radiology
- ☐ Mammography
- ☐ Myelography
- ☐ Nuclear Medicine
- ☐ Radiation Oncology
- ☐ Radiopaque Dye
- ☐ Teleradiology
- ☐ Other: _____

Other Procedures

- ☐ Electroconvulsive Therapy
- ☐ Fertility Treatments
- ☐ Lithotripsy
- ☐ Organ Transplant
- ☐ Prenatal Care
- ☐ Prolotherapy
- ☐ Weight Control – Medication Prescriptions
- ☐ Wound Care
- ☐ Other: _____

Surgical Procedures

- ☐ Assisting in Surgery – Own Patients
- ☐ Assisting in Surgery – Other Than Own Patients
- ☐ Abortion
- ☐ Adenoidectomy
- ☐ Angioplasty/Angiography/Arteriograph
- ☐ Bariatric Surgery
- ☐ Breast Biopsy
- ☐ Bronchoscopy
- ☐ Chelation Therapy
- ☐ Cholecystectomy
- ☐ Circumcision
- ☐ Colonoscopy
- ☐ Cryosurgery
- ☐ Cystoscopy
- ☐ D&Cs

Surgical Procedures (continued)

- ☐ Endoscopy
- ☐ Fracture Reductions Open/Closed
- ☐ Hemorrhoidectomy
- ☐ Hyperbaric Medicine
- ☐ Hysterectomy
- ☐ Laser Surgery
- ☐ Lasik Surgery
- ☐ Penile Implants
- ☐ Robotic Surgery
- ☐ Sex Reassignment Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Other: _____

Surgical Procedures (continued)

Cardiac Surgery

- ☐ Arterial Catheterization
- ☐ Left Heart Catheterization
- ☐ Pacemaker - Permanent
- ☐ Right Heart Catheterization

Orthopedic Surgery

- ☐ Spinal Surgery
- ☐ No Spinal Surgery

Obstetrics-Gynecology Surgery

- ☐ Cesarean
- ☐ Vaginal After Cesarean
- ☐ Vaginal Deliveries

Plastic Surgery

- ☐ Elective Cosmetic Surgery

☐ I DO NOT PERFORM ANY OF THE ABOVE PROCEDURES

10. Do you perform any procedure that is outside the practice of your specialty or sub-specialty? ☐ Yes ☐ No

If "Yes,"please explain:

11. Do you:

a. Practice telemedicine? ☐ Yes ☐ No

b. Work in correctional institutions? ☐ Yes ☐ No

c. Work in research or clinical trials? ☐ Yes ☐ No

d. Provide medical services for any professional sport organizations? ☐ Yes ☐ No

e. Contract with or have you ever contracted with any skilled nursing facility, convalescent hospital, nursing home or similar facility? ☐ Yes ☐ No

f. Serve as a medical director for any organization? ☐ Yes ☐ No

If "Yes" to any of the above, please provide details:

12. Have you ever:

a. Been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? ☐ Yes ☐ No

b. Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐ Yes ☐ No

c. Been treated for any alcohol, narcotics or any substance abuse? ☐ Yes ☐ No

d. Had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐ Yes ☐ No

e. Had hospital privileges reduced, suspended or revoked? ☐ Yes ☐ No

f. Had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐ Yes ☐ No

D. CURRENT AND REQUESTED COVERAGE

13. Current carrier: _____ Retroactive date: _____

Current limits: Each claim: _____ Aggregate: _____

14. Are you requesting prior acts coverage? ☐ Yes ☐ No

If "No," have you obtained prior acts coverage from another carrier? ☐ Yes ☐ No

15. **MISSOURI RESIDENTS - DO NOT ANSWER THIS QUESTION**. Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for you? ☐ Yes ☐ No

If "Yes," please provide details:

E. CLAIMS HISTORY

16. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against you? ☐ Yes ☐ No

If "Yes," please provide a completed Physician Claim Supplement for each such claim.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 16 IS EXCLUDED FROM THE PROPOSED INSURANCE.

17. Are you aware of any fact, circumstance, situation, transaction, event, act, error or omission that you have reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please attach details for this Application.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 17 IS EXCLUDED FROM THE PROPOSED INSURANCE.

F. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND 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.

ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she 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, which is a crime.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

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.

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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO AND RHODE ISLAND 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.

MAINE, TENNESSEE, VIRGINIA 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.

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.

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

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA 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 such person to criminal and civil penalties.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

G. SIGNATURE AND AUTHORIZATION

The undersigned declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application and the application submitted by the Applicant Entity is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance upon this Application and the application submitted by the Applicant Entity, and this Application and the application submitted by the Applicant Entity will be the basis of the contract.

The Underwriter will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind you or the Underwriter to complete the insurance or issue a policy. The information provided in this Application is for underwriting purposes only and does not constitute notice to the Underwriter under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify the Underwriter immediately and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

NEW YORK 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Physician Signature		
Print Name		Date

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PHYSICIAN CLAIM SUPPLEMENT

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS AND REPRESENTATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

Instructions:

This form must be completed if any physician proposed for this insurance has knowledge of any claim, suit or potential claim in which he/she is named or may become involved. Please complete one Physician Claim Supplement for each such claim, suit or potential claim. Use separate sheets if necessary.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the application submitted for the proposed insurance):	

B. CLAIM INFORMATION

2. Physician name:		
3. Name of patient or claimant:	☐ Male ☐ Female	Age:
4. Location of incident:		
5. Date of incident:		
6. Physician's relationship to the patient/claimant (attending physician, assistant surgeon, etc.)		
7. Insurance carrier:		

8. Current status: ☐ Open ☐ Closed If closed, date closed: _____

9. Please provide the following information (as applicable):

a. Open reserve amount $ _____ b. Closed loss amount $ _____

c. Settlement total amount $ _____ d. Judgment total amount $ _____

Your portion $ _____ Your portion $ _____

10. Name of other physician(s) and hospital(s), if any, involved in the claim, suit or potential claim:

11. Allegation(s):

12. Condition and diagnosis of patient at time of treatment:

13. Description of medical treatment rendered to patient:

14. Condition of patient subsequent to treatment:

C. SIGNATURE AND AUTHORIZATION

The undersigned declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement and any attachments or information submitted with this Supplement are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement and any attachments or information submitted with this Supplement are true and complete. The undersigned understands that this Supplement and any such attachments or information submitted herein are part of the application submitted by or on behalf of the Applicant for the proposed insurance, and are subject to the representations and conditions set forth therein.

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NEW YORK 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Physician Signature		
Print Name		Date