General Star National Insurance Company

**NEW BUSINESS APPLICATION**
**PROFESSIONAL LIABILITY INSURANCE**

# ANESTHESIOLOGISTS CLAIMS-MADE AND REPORTED COVERAGE

*Please complete this application in ink and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.*

**INSTRUCTIONS TO THE APPLICANT:**

- You must provide a fully completed application, signed and dated by you within 45 days of the desired effective date of coverage.
- Appropriate Supplementary Applications, Claim Information Supplement(s) and additional documentation must also be completed as needed.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The following additional information must be provided:
  - Copy of your current professional liability insurance Declarations Page.
  - Copy of your Curriculum Vitae.
  - Copies of all advertising that you use.
  - Copy of your business letterhead.
  - Company loss runs, valued within the last 90 days.

## I. GENERAL INFORMATION

Social Security #: ___________________________

Applicant's Name:_______________________________________________ Date of Birth: _______________

Professional Designation: ☐ M.D. ☐ D.O.

1. Mailing Address:_____________________________________________________________________
Street/P.O. Box City County State Zip Code

2. Primary Practice Location:_____________________________________________________________ Number of years at this location: _______
Street City County State Zip

Do you have more than one practice location? **If YES**, on a separate sheet please provide the following information: location address, hours of operation, procedures performed at each location, number of years at each location. ☐ Yes ☐ No

3. Office Telephone:______________________________ E-mail: ________________________________
Office facsimile: ______________________________ Web Site:________________________________

4. Applicant is a(n): ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership
☐ Employed Physician By Whom ________________________________________
☐ Other (describe):_____________________________________________________

Practice is a: ☐ Solo Practice ☐ Group Practice
Entity Name: ______________________________________ Applicant's percentage of ownership: ____%
How many other physicians practice at this entity? _______

Do you use any "doing business as" (d/b/a) name?
**If YES**, specify: _____________________________________________ ☐ Yes ☐ No

5. Residence Address:_____________________________________________________________________
Street/P.O. Box City County State Zip Code
Residence Telephone: _________________________


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## II. MEDICAL TRAINING & EDUCATION

1. Percentage of Practice:

Medical Specialty: ______________________________________________ _______%

Sub-Specialty: ______________________________________________ _______%

2. Date you began practicing medicine:______________

| 3. | Hospital / College | City & State | Completed? | Dates – From / To |
|---|---|---|---|---|
| Medical School | | | ☐ Yes ☐ No | |
| Internship | | | ☐ Yes ☐ No | |
| Residency | | | ☐ Yes ☐ No | |
| Fellowship | | | ☐ Yes ☐ No | |

4. Are you a U.S. citizen? **If NO**, please provide a copy of documents confirming your status. ☐ Yes ☐ No

5. Are you a Foreign Medical School Graduate? **If YES**, please provide: ☐ Yes ☐ No
   Date of ECFMG certification: ______________

6. Are you currently Certified by any board recognized by the **American Board of Medical Specialties**? **If YES**, please provide: ☐ Yes ☐ No
   Name of Board: __________________________________ Certificate expiration: _________

7. Are you a member of any medical association? **If YES**, please list memberships: ☐ Yes ☐ No
   ____________________________________________
   ____________________________________________

8. Please indicate the number of CME hours you have completed in the past two years:________________

## III. MEDICAL PRACTICE HISTORY

1. Within the last five (5) years have your practice characteristics, procedures performed, or business association(s) changed? **If YES**, please describe on additional sheet. ☐ Yes ☐ No

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

| Street Address & City | County | State | Dates – From / To |
|---|---|---|---|
| | | | |
| | | | |

3. List all hospitals where you have staff privileges:
   (*If no hospital privileges, attach protocol for patient hospital admission)*

| Hospital | City / State | County | % of Practice | Type of privilege |
|---|---|---|---|---|
| | | | | |
| | | | | |

4. List all locations where you practice:

| Name of facility | City / State | County | % of Practice | Surgery Center (S) or Office (O) |
|---|---|---|---|---|
| | | | | |
| | | | | |

| 5. List all states where you practice or have a medical license: | **Medical License Number(s):** | **DEA License Number(s):** | **% of practice in each state:** |
|---|---|---|---|
| | | | |
| | | | |



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| | | | |
|---|---|---|---|
| | | | |

6. Legal / Professional / Administrative Actions against you:
   a. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? **If YES,** please describe on separate sheet. ☐ Yes ☐ No
   b. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? **If YES,** please describe on separate sheet. ☐ Yes ☐ No
   c. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If YES,** please explain on a separate sheet. ☐ Yes ☐ No
   d. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? **If YES,** please complete **Substance Impairment Supplemental Application**. ☐ Yes ☐ No
   e. Have you ever been charged with, or convicted of a crime other than minor traffic violations? **If YES,** please explain on a separate sheet. ☐ Yes ☐ No
   f. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s), or a state licensing authority? **If YES,** please explain on a separate sheet. ☐ Yes ☐ No

## IV. OFFICE STAFF

1. Do you employ, contract with, or supervise any **physician(s) or surgeons(s)**? **If YES,** enter information below and attach current certificate(s) of insurance. ☐ Yes ☐ No

| Physician/Surgeon Name | Medical Specialty | Limits of Liability | Employ (E) Contract (C) Supervise (S) | Insurer |
|---|---|---|---|---|
| | | | ☐E ☐C ☐S | |
| | | | ☐E ☐C ☐S | |
| | | | ☐E ☐C ☐S | |
| | | | ☐E ☐C ☐S | |

2. Do you employ, contract with, or supervise any non-physician health care extenders? **If YES,** enter information below: ☐ Yes ☐ No

| TYPE | NUMBER EMPLOYED | NUMBER SUPERVISED ONLY | TYPE | NUMBER EMPLOYED | NUMBER SUPERVISED ONLY |
|---|---|---|---|---|---|
| CRNA | | | Pharmacist | | |
| Nurse Practitioner | | | Nurse (RN/LPN) | | |
| Physician Assistant | | | Surgeon Assistant | | |
| Medical Lab Technician | | | | | |

☐ OTHER (Please provide detail on separate page)

## V. PROCEDURES/PRACTICE SPECIFICS

| | |
|---|---|
| 1. a. Average Weekly Patient Encounters: | |
| b. Average Weekly Practice Hours: | |
| c. Percentage Of Locum Tenens Work: | % |

2. 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? **If YES**, please describe on separate sheet. ☐ Yes ☐ No


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| 3. Anesthesia Practice Devoted to the Following (check all that apply) | Local (l) or General (g) If applicable | Approximate Percentage of Total Practice | Are the Majority of Procedure Performed in a: hospital (h) office (o) or surgicenter(s)? |
|---|---|---|---|
| □ Pediatric | | | |
| □ Neuro | | | |
| □ Vascular | | | |
| □ Open Heart | | | |
| □ Intensive Care Mgmt. | | | |
| □ OB | | | |
| □ Transplant | | | |
| □ Trauma | | | |
| □ Other: | | | |
| Pain Management Procedures | | | |
| □ Drug Treatment (Opiods, antidepressants, corticosteroids, etc.) | | | |
| □ PCA Pumps | | | |
| □ TENS | | | |
| □ Electro thermal Therapy | | | |
| □ Trigger Point Injections | | | |
| □ Nerve/Facet Joint Blocks | | | |
| □ Epidural Injections/Non-OB related | | | |
| □ Spinal Cord Stimulation | | | |
| □ Spinal Drug Delivery System | | | |
| □ Other: | | | |

4. Do you own or operate a Laboratory? **If YES**,
   a. Does the laboratory provide services solely for your patients? ☐ Yes ☐ No
   b. If not limited to your patients, please explain on separate sheet. ☐ Yes ☐ No

5. a. Are you now performing experimental or investigational procedures or prescribe or dispense experimental drugs? ☐ Yes ☐ No
   b. Have you ever performed experimental or investigational procedures or prescribed, dispensed experimental drugs? ☐ Yes ☐ No
   If YES to either of the above, please explain on a separate sheet.

6. a. Do you now treat prisoners in a state, federal or any correctional institution? ☐ Yes ☐ No
   **If YES**, please complete the **Correctional Facility Supplemental Application**.
   b. Have you ever treated prisoners in a state, federal or any correctional institution? ☐ Yes ☐ No
   **If YES**, please provide last date of treatment.___________________________

7 Do you practice as a company doctor (excluding treatment of workers compensation patients)? ☐ Yes ☐ No
   **If YES,**
   a. What products are manufactured by the company? _______________________
   b. Do you review or establish plant / employer safety standards? ☐ Yes ☐ No
   c. Do you provide medical treatment to company employees? ☐ Yes ☐ No
   d. Company name:___________________________________ Location: ______________

8. Do you work in an Emergency Room? ☐ Yes ☐ No
   b. **If YES**, is this solely to satisfy requirements for hospital privileges? ☐ Yes ☐ No
   c. Indicate the average number of hours you work in the Emergency Room each month: _____________


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9. Are you a sports team physician or health care provider? **If YES,** check all that apply: ☐ Yes ☐ No
☐ High School ☐ College ☐ Professional Other:___________________
Name and location of team(s): ______________________________________________________

10. Do you treat patients in a Nursing Home, Hospice Care or similar care facility? ☐ Yes ☐ No
If YES, how many patients currently reside in a Nursing Home, Hospice Care or similar care facility? _____________

11. Indicate if you now, or have ever been, any of the following at any Nursing Home, Hospital, Hospital Department, Sanitarium, HMO, PPO, Ambulatory Care Clinic with bed and board facilities, or any other business enterprise?

| | Now | % of Practice | In the Past | % of Practice | Type of Facility (identify from list above) |
|---|---|---|---|---|---|
| Proprietor | ☐ | ____% | ☐ | ____% | |
| Partner | ☐ | ____% | ☐ | ____% | |
| Officer | ☐ | ____% | ☐ | ____% | |
| Director | ☐ | ____% | ☐ | ____% | |
| Administrator | ☐ | ____% | ☐ | ____% | |
| Executive Director | ☐ | ____% | ☐ | ____% | |
| Medical Director | ☐ | ____% | ☐ | ____% | |
| Contractor | ☐ | ____% | ☐ | ____% | |
| Provider of Services | ☐ | ____% | ☐ | ____% | |
| Employee | ☐ | ____% | ☐ | ____% | |

**If YES,** provide name(s) of facilities and explain details:
______________________________________________________________________________
______________________________________________________________________________

12. Do you prescribe drugs or provide diagnosis via the Internet? **If YES,** please describe on separate sheet. ☐ Yes ☐ No

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

## VI. PRIOR POLICY AND LOSS INFORMATION

1. Please provide the following information pertaining to your past 5 years of professional liability coverage:

| Policy Period | Insurance Carrier | Policy Limits | Deductible | Type of Policy | Premium | * Total # of Claims |
|---|---|---|---|---|---|---|
| | | | | ☐ CM ☐ Occ | | |
| | | | | ☐ CM ☐ Occ | | |
| | | | | ☐ CM ☐ Occ | | |
| | | | | ☐ CM ☐ Occ | | |
| | | | | ☐ CM ☐ Occ | | |

**✳Total # of claims, by carrier, regardless of payment, no-payment, dismissal or status.**

2. Have you ever practiced without professional liability insurance? ☐ Yes ☐ No
**If YES**, specify dates: from _________________ until _______________________

3. Have you ever had any insurance company decline, cancel, rescind or non-renew any Professional Liability Insurance Policy? *(Response not required in the State of Missouri)* ☐ Yes ☐ No
**If YES**, please provide details:
_________________________________________________________________________
_________________________________________________________________________

4. Are you aware of any of the following:
   a. known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ Yes ☐ No
   b. facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that has not been reported to a prior insurance carrier? ☐ Yes ☐ No


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c. any request for medical records by a patient or his/her attorney which might result in a claim? ☐ Yes ☐ No

d. information relating to service(s) on a Board which might result in a claim? ☐ Yes ☐ No

e. any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, claim, threat of claim, letter of intent, adverse result notice or attorney contact? ☐ Yes ☐ No

f. any involvement, now or ever, in any Professional Liability claim or suit? **If YES,** a **Claim Information Supplemental Application** *must* be completed for each claim. ☐ Yes ☐ No

**If YES** to any of the above, please provide details:

______________________________________________________________________________

______________________________________________________________________________

## VII. COVERAGE REQUESTED

***NOTE: The Company may not offer or quote requested coverage.***

**Effective Date:** ________________ **Retroactive Date:** ________________

*Important: Declarations Page of your current policy must be attached if a retroactive date is requested.*

| **Limits of Liability:** | | **Deductible:** | |
|---|---|---|---|
| ☐ | $ 100,000 / $ 300,000 | ☐ | None |
| ☐ | $ 200,000 / $ 600,000 | ☐ | $ 5,000 |
| ☐ | $ 250,000 / $ 750,000 | ☐ | $7,500 |
| ☐ | $1,000,000 / $3,000,000 | ☐ | $10,000 |
| ☐ | Other $_____________ | ☐ | Other $__________ |

## VIII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

**PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.**

**By signing this Application, you represent and agree to each of the following five (5) items:**

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and

2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):

   ☐ Statement of No Known Claims Letter ☐ Other

   ☐ Claim Information Supplemental Application

3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:

   a. Accurate, true and complete to the best of your knowledge;
   b. No material facts have been suppressed or misstated;
   c. Representations you are making on behalf of all persons and entities proposed to be insured;
   d. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.



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4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.

5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

**Notice to Applicants of all states except Colorado, New York, and Pennsylvania**
**Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes 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 and denial of insurance benefits.**
**Notice to 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.**
**NEW YORK FRAUD WARNING: 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.**
**Notice to Pennsylvania Applicants:**
**Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes 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.**

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

*COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.*

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

______________________________________ ____________________
Signature of Applicant Date

______________________________________
Print or Type Name and Title


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