GeneralStar
Beyond Security®

SUPPLEMENTAL APPLICATION
MEDICAL MARIJUANA
PHYSICIANS & SURGEONS
Claims-Made and Reported Coverage

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

I. GENERAL INFORMATION

Applicant Name:	
Entity Name	
Primary Office Address:	Telephone No.:
City:	County:
State:	ZIP:

II. TRAINING and PRACTICE PROFILE

1. Do you use a standard form when you recommend medical marijuana? ☐ Yes ☐ No
   Does it have an expiration date? ☐ Yes ☐ No
2. Do you use a specific informed consent for medical marijuana? ☐ Yes ☐ No
3. Did you receive any specific training to inform your recommendation for medical marijuana? ☐ Yes ☐ No
4. Do you provide services at a location adjacent to a dispensary or a cultivation center? ☐ Yes ☐ No
5. Do you or any family member receive compensation directly or indirectly from or hold a financial interest in a dispensary or cultivation center? ☐ Yes ☐ No
6. Do you use a Treatment Agreement with your medical marijuana patients? ☐ Yes ☐ No
7. Do you subscribe or pay a fee to any services which match patients with physicians such as www.MedicalMarijuana.com or www.marijuanabreak.com? ☐ Yes ☐ No
8. Does your state specify the medical conditions for which a patient may qualify for marijuana? ☐ Yes ☐ No
9. What percentage of your patients seen in the last twelve month period were given recommendations for medical marijuana? _____ %
10. Please estimate the percentage of medical marijuana recommendations for the following ailments:

Arthritis	_____ %	Chronic Pain	_____ %
Epilepsy	_____ %	Glaucoma	_____ %
Multiple Sclerosis	_____ %	Cancer	_____ %
Crohn's Disease	_____ %	Fibromyalgia	_____ %
HIV/AIDS	_____ %	Severe Nausea	_____ %
Other	_____ %	_____	

Additional Information:

_____

_____

VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

This applicant declares that the information contained in this supplemental application is true and that no material facts have been suppressed or misstated. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. This applicant understands that incorrect information could void coverage.

Signature: _____ Date: _____

Printed Name: _____ Title/Position (Officer, Partner, etc): _____