GeneralStar
Beyond Security®

SUPPLEMENTAL APPLICATION

SUBSTANCE IMPAIRMENT

PHYSICIANS AND 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

1. Applicant Name:

2 Please specify the addiction for which you have been treated:
- ☐ Alcohol
- ☐ Amphetamines
- ☐ Cocaine
- ☐ IV Opiates/Narcotics
- ☐ Other (specify):

3
- a Are you currently participating in a treatment program? ☐ Yes ☐ No
- b **If YES**, does the program include random drug screening? ☐ Yes ☐ No

4 Please provide the following information regarding your treatment program:
Name of Program:
Location: (street address, city, state)
Monitoring Physician (Name, Business Phone):

5 Please describe the status of your treatment program: ☐ Yes ☐ No
- ☐ None or non-completion
- ☐ Outpatient
- ☐ Inpatient less than 1 month
- ☐ Inpatient more than one month. Length of stay
- ☐ Other (specify):

- a If you have completed the treatment program, please specify the completion date:
- b If you have completed a treatment program, have you experienced any relapses?
- c IF YES, describe the number of times and the circumstances:

6
- a Are you participating in a 12-step program? ☐ Yes ☐ No
- b **If YES**, Number of meetings attended weekly:

7 Please specify the length of your sobriety:

- ☐ Less than six months
- ☐ Six months to one year
- ☐ One to two years
- ☐ Two to three years
- ☐ Three to four years
- ☐ Four to five years
- ☐ More than five years

8 Please describe any licensure, legal or criminal actions have been taken against you to date:

VII. 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 the following:

FRAUD WARNING

Notice to Applicants of all states except Colorado, Maryland, 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.

Notice to Maryland Applicants:
Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

Notice to 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 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:	**Date:**
Print or Type Name and Title:	