General Star Indemnity Company

NEW BUSINESS APPLICATION-SHORT FORM
PROFESSIONAL LIABILITY INSURANCE

PHYSICIANS AND SURGEONS CLAIMS–MADE COVERAGE

Please complete this application 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. To use this form, you may mouse click on or select a field and move between fields using the tab key.

I. GENERAL INFORMATION

Entity Name: _____

Address: _____
Street/P.O. Box

_____
City County State Zip Code

II. PHYSICIAN INFORMATION

Applicant's Name: _____

Medical Specialty: _____ Date of Birth: _____

Professional Designation: ○ M.D. ○ D.O. ○ D.P.M. Other (describe) _____

Are you currently **certified** by any board recognized by the American Board of Medical Specialties?
If **YES**, please provide information:
Name of Board: _____ Certificate Expiration: _____ ○ Yes ○ No

III. MEDICAL PRACTICE HISTORY

1. 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 a 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 a 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 the **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 state licensing authority? If **YES**, please explain on a separate sheet. ○ Yes ○ No
   g. Please specify the number of hours worked per week. _____
   h. Please specify the number of patients per week. _____

2. Does your practice include the following? Check all that apply.

☐	No Surgery	No surgery with the exception of the following procedures: sutures of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision, and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.
☐	Minor Surgery	Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: ▪ Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangliopancreatography (ERCP), ▪ Pneumatic or mechanical esophageal dilation (not with bougle or olive), ▪ Angiography; Arteriography; Catheterization – arterial, cardiac, or diagnostic (applies only to internists who have completed a cardiovascular subspecialty training.) ▪ Needle biopsy including lung, breast, prostate, and superficial and subcutaneous tissue, ▪ Radiopaque Dye Injection into blood vessels, lymphatics, sinus tracts or fistulae ***No procedures performed on a patient while under general anesthesia.***
☐	Major Surgery	Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or length of circumstances of an operation. It includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography, and radiation therapy. It also includes, removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoldectomies, cesarean sections, and any other operation using general anesthesia.

IV. PRIOR POLICY AND LOSS INFORMATION

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

2. Are you aware of any of the following actions:

a.	Known losses or claims that have not been reported to a prior insurance carrier or any other sources from which payment might be made?	○ Yes	○ No
b.	Facts or circumstances that relate to a medical incident(s) arising from professional service, which could reasonably result in a claim that has not been reported to a prior insurance carrier?	○ Yes	○ No
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?	○ Yes	○ No

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

V. 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 required.

VI. 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 that:

1. You have made a comprehensive investigation to determine whether anyone in you 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. Each of the statements and answers given in this Application, and in each Supplemental Applications required, 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.
3. This Application, along with any Supplemental Application required, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, and regardless of 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.
4. 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.

FRAUD WARNING

Notice to Applicants of all states except New Jersey, New York, Pennsylvania, and Washington D.C.:
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 purpose 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 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.

Notice to New York 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 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 provision.

Notice to Pennsylvania Applicants:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Notice to Washington D.C. 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.

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 BE ATTACHED TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer and is not subject to the financial solvency regulation and enforcement, which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

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	