☐ General Star Indemnity Company
☐ General Star National Insurance Company

General Star Select
APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE

Submitted By:
Producer:______________________________ Contact:______________________
Name:______________________________ Phone:___________________
Address:______________________________ City:______________________ State:_______ Zip:___________

Please complete this application in ink and answer all questions. An incomplete application cannot be processed. If a question does not apply to your practice, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please use the space provided on the last page of this application or attach a separate page. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

THE FOLLOWING MUST BE INCLUDED WITH THIS APPLICATION:

- This fully completed application, signed and dated by you within 45 days of the desired effective date.
- Copy of your current professional liability insurance Declarations Page and currently valued loss experience.
- Copy of your Curriculum Vitae.
- Copies of all advertising that you use, including Yellow Page ads.
- Copy of your business letterhead.
- Supplementary Applications, Claim Information Supplement(s) and additional documentation as needed.

I. GENERAL INFORMATION

1. Print Name:

Social Security No.

2. Professional Designation:

☐ M.D. ☐ D.O.

3. Date of Birth:

4. Type of Practice:
☐ Solo Practice ☐ Group Practice

Group Name:

5. Business Name: % of Ownership

☐ Corporation ☐ Limited Liability Company ☐ Partnership
On a separate sheet, please list all Physician Partners or Stockholders: (indicate if you are the sole owner)
☐ An Employed Physician? - Employer:
☐ Other: (Specify)

6. Do you use any "Doing Business As" (d/b/a) name? ☐ Yes ☐ No **If YES, specify:**

7. Primary Practice – Street Address: *(If more than one location, list on additional sheet)*

Number of years at this location:

8. City: County: State: Zip:

9. Billing Address (If different from above):	City:	State:	Zip:

10. Office Telephone:	Fax:	Residence Telephone:	E-Mail Address:

MEDICAL TRAINING AND PRACTICE HISTORY

11. Medical Specialty: Percent of Practice: %	12. Medical Sub-Specialty: Percent of Practice: %

	Hospital / College	City & State	Completed?	Year
Medical School			☐ Yes ☐ No	
Internship			☐ Yes ☐ No	
Residency			☐ Yes ☐ No	
Additional Residency			☐ Yes ☐ No	
Fellowship			☐ Yes ☐ No	

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

14. Are you a Foreign Medical School Graduate? ☐ Yes ☐ No Date of ECFMG certification: ______________

15. Are you currently Certified by any board recognized by the American Board of Medical Specialties? ☐ Yes ☐ No
Name of Board:

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

17. 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**

18. Please list below all hospitals where you practice (*If no hospital privileges, attach protocol for patient hospital admission)*

Hospital	**City / State**	**County**	**% of Practice**	**Type of privilege**

19. **List states where you practice:**	**Medical License Number(s):**	**DEA License Number(s):**	**% of practice in each state:**

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

II. OFFICE STAFF

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

Name	Medical Specialty	Limits of Liability	Insurer

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

	Number	Insurer, If any		Number	Insurer, If any
Nurse Practitioner			Surgeon Assistant		
CRNA			Laboratory Technician		
Nurse Midwife			X-ray Technician		
Nurses (other)			Optometrists		
Physician Assistant			Pharmacist		

Other non-physician health care extenders, not listed above (please describe):

III. PRACTICE INFORMATION

23. Average Number of patients seen each week: _______ Weekly practice hours: ______
Percentage of Locum Tenens work: ______%

24. Please list any medical association membership(s): ____

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

26. Do you perform abortions? ☐ Yes ☐ No **If YES**, indicate number each month:_________
Type: ☐ Elective ☐ Therapeutic Maximum Gestation Age?__________

Where performed? (Check all that apply) ☐ Office ☐ Hospital ☐ Other (Explain on separate sheet)

27. Does your practice include the following (Check all that apply)?

☐ No Surgery — No surgery, with the exception of suture 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, sigmiodoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP),
- Pneumatic or mechanical esophageal dilation (not with bougie or olive),
- Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists that 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 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 the 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, adenoidectomies, cesarean sections and any other operation using general anesthesia.
☐ Obstetrics		If checked, please indicate annual numbers: Number of vaginal deliveries:_______ Number of cesarean sections:______ Number of Home or Non-Hospital Deliveries:_________ (Please describe on separate sheet)
☐ Radiology		Indicate the annual number of readings performed: _____________ Type of readings performed:____ ____
☐ Elective Plastic Surgery		Please describe procedures and annual number performed on separate sheet

28. Do you perform any of the following procedures?

Acupuncture?	☐ Yes ☐ No	Laparoscopies?	☐ Yes ☐ No
Adenoidectomy?	☐ Yes ☐ No	Laser Treatments Via Endoscope?	☐ Yes ☐ No
Amniocentesis?	☐ Yes ☐ No	Low Forceps Deliveries?	☐ Yes ☐ No
Amputations?	☐ Yes ☐ No	Malignant Lesion Surgical Procedures?	☐ Yes ☐ No
Anal Fissure?	☐ Yes ☐ No	Mastoidectomy?	☐ Yes ☐ No
Angiography?	☐ Yes ☐ No	Middle or Inner Ear Surgery?	☐ Yes ☐ No
Arterial Catheterization?	☐ Yes ☐ No	Mid-Forceps Delivery?	☐ Yes ☐ No
Arteriography?	☐ Yes ☐ No	MOHS Micrographic Surgery?	☐ Yes ☐ No
Assisting in surgery on other than your own patients?	☐ Yes ☐ No	Myleography?	☐ Yes ☐ No
Assisting in surgery on your own patients?	☐ Yes ☐ No	Needle Biopsies?	☐ Yes ☐ No
Blepharoplasty?	☐ Yes ☐ No	Neurological Surgery?	☐ Yes ☐ No
Breast Augmentation or Reduction	☐ Yes ☐ No	Norplant Insertion?	☐ Yes ☐ No
Breech Deliveries?	☐ Yes ☐ No	Obesity/Weight Control Surgery?	☐ Yes ☐ No
Catherizations? (Right Heart)	☐ Yes ☐ No	Office Gynecology?	☐ Yes ☐ No
Cervical Biopsy?	☐ Yes ☐ No	Oophorectomy?	☐ Yes ☐ No
Cervical Cautery?	☐ Yes ☐ No	Open Reduction of Fractures?(Plating and Pinning)	☐ Yes ☐ No
Chelation Therapy?	☐ Yes ☐ No	Ophthalmologic Surgery?	☐ Yes ☐ No
Chemical Peels?	☐ Yes ☐ No	Ophthalmologic Surgery? (LASIK)	☐ Yes ☐ No
Cleft Lip or Palate Surgery?	☐ Yes ☐ No	Orchidectomy?	☐ Yes ☐ No
Clinical Trials?	☐ Yes ☐ No	Organ Transplants?	☐ Yes ☐ No
Closed Reduction of Fractures?	☐ Yes ☐ No	Orthopedic Surgery? (Including Spinal Surgery)	☐ Yes ☐ No
Cholecystectomies?	☐ Yes ☐ No	Orthopedic Surgery? (No Spinal Surgery)	☐ Yes ☐ No
Collagen Lip Injection?	☐ Yes ☐ No	Otoplasty?	☐ Yes ☐ No
Colonoscopy?	☐ Yes ☐ No	Pedicle Screw Insertion?	☐ Yes ☐ No
Complex Flaps and Grafts	☐ Yes ☐ No	Penile Augmentation?	☐ Yes ☐ No
Conization of Cervix?	☐ Yes ☐ No	Penile Implants?	☐ Yes ☐ No
Culdocentesis?	☐ Yes ☐ No	Pericardiocentesis?	☐ Yes ☐ No
Diagnostic Radiology?	☐ Yes ☐ No	Permanent Eyeliner Procedures?	☐ Yes ☐ No
Dilation and Curettage?	☐ Yes ☐ No	Photorefractive Keratotomy?	☐ Yes ☐ No
Electroshock Therapy?	☐ Yes ☐ No	Pregnancy Care into Second Trimester?	☐ Yes ☐ No
Endometrial Biopsy?	☐ Yes ☐ No	Pregnancy Care into Third Trimester?	☐ Yes ☐ No
Endoscopic Retrograde/Cholangiopancreatography?	☐ Yes ☐ No	Prostatectomy?	☐ Yes ☐ No
Episiotomy?	☐ Yes ☐ No	Radial Keratotomy?	☐ Yes ☐ No
Experimental Procedures?	☐ Yes ☐ No	Radiation Therapy? (Radium Implants)	☐ Yes ☐ No
Gastric Bubble Procedures?	☐ Yes ☐ No	Reconstructive Plastic Surgery?	☐ Yes ☐ No
Hair Transplant Procedures?	☐ Yes ☐ No	Salpingectomy?	☐ Yes ☐ No

Hemorrhoidectomies?	☐ Yes ☐ No	Scalp Reduction Surgery?	☐ Yes ☐ No
Hernioplasty?	☐ Yes ☐ No	Sex Change Operations?	☐ Yes ☐ No
High Risk Pregnancies	☐ Yes ☐ No	Sterilization Procedures?	☐ Yes ☐ No
Hyperbaric Chamber Treatments?	☐ Yes ☐ No	Suction Lipectomy Procedures?	☐ Yes ☐ No
Hypnosis?	☐ Yes ☐ No	Thrombectomy of Arteries and Veins?	☐ Yes ☐ No
Hysterectomies?	☐ Yes ☐ No	Toxemia Management?	☐ Yes ☐ No
Interphalangeal Joint Surgery?	☐ Yes ☐ No	Tubal Ligation?	☐ Yes ☐ No
Joint Replacement Surgery?	☐ Yes ☐ No	Vascular Surgery?	☐ Yes ☐ No
Kidney, Ureter and Bladder Surgery?	☐ Yes ☐ No	Other, List	☐ Yes ☐ No

29. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? **IF YES,** please describe on separate sheet.	☐ Yes ☐ No
30. 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
31. Are you now, or have you ever been involved in any Professional Liability claim or suit? **IF YES**, a **Claim Information Supplement** form *must* be completed for each claim.	☐ Yes ☐ No
32. Are you aware of any circumstances that might lead to a claim or suit? **IF YES**, complete a **Claim Information Supplement** for *each* circumstance.	☐ Yes ☐ No
Has this information been reported to a current or prior insurance carrier?	☐ Yes ☐ No
33. Has your Professional Liability insurance ever been refused, canceled or non-renewed? **IF YES,** please explain on a separate sheet. *(Response not required in the State of Missouri)*	☐ Yes ☐ No
34. 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
35. 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 supplemental application.	☐ Yes ☐ No
36. 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
37. 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
38. Do you own or operate a Laboratory? ☐ Yes ☐ No **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.	
39. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? **IF YES,** please explain on a separate sheet.	☐ Yes ☐ No
40. Do you now or have you ever treated prisoners in a state, federal or any correctional institution? **IF YES**, please explain on a separate sheet.	☐ Yes ☐ No
41. Do you practice as a company doctor (excluding treatment of workers compensation patients)?	☐ Yes ☐ No
IF YES, what products are manufactured by the company? ________________________	
Do you review or establish plant / employer safety standards?	☐ Yes ☐ No
Do you provide medical treatment to company employees?	☐ Yes ☐ No
Company name:____ Location: ______________	

42. Does your practice include weight reduction/control by other than diet and exercise? **IF YES,** please complete the information below or attach separate sheet if needed: a. What percentage of patients are treated exclusively for weight control? ___________% b. List injections used for weight control: ______________________________________ c. If you prescribe or dispense drugs for weight control, please list drugs and describe protocols:____ d. Describe any other weight control procedures, including surgery, that you provide to your patients: ____	☐ Yes ☐ No
43. Do you authorize any collection agency, at it's own discretion, to file a claim or suit?	☐ Yes ☐ No
44. Do you work in an Emergency Room for other than maintaining hospital privileges? Please indicate the average number of hours you work in the Emergency Room each month:_______________________________	☐ Yes ☐ No
45. Are you a sports team physician or health care provider? **IF YES,** check all that apply: ☐ High School ☐ College ☐ Professional ☐ Other:___________________ Name and location of team(s)? ____	☐ Yes ☐ No
46. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director, or are you providing professional services, at any Nursing Home or similar facility? **IF YES**, describe percentage of your practice and name(s) of nursing home facilities: ____ ____	☐ Yes ☐ No
47. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director of a hospital or hospital department; sanitarium; ambulatory care clinic with bed and board facilities; health maintenance organization; preferred provider organization; or any other business enterprise? **IF YES, please identify, provide address, and explain details on a separate sheet.**	☐ Yes ☐ No
48. Do you serve in a "Gatekeeper" capacity (that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization)? **IF YES,** please advise of percentage of your practice devoted to Gatekeeper activity: ___%	☐ Yes ☐ No
49. Do you engage in tele-medicine activity? IF YES, please describe on separate sheet.	☐ Yes ☐ No
50. Do you prescribe drugs or provide diagnosis via the Internet? **IF YES**, please describe on separate sheet.	☐ Yes ☐ No
51. 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

IV. ANESTHESIA / OFFICE SURGERY

52. Do you perform or assist in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis? **IF YES,** please complete the questions below: ☐ Yes ☐ No

a. Description and annual number of procedures:
____
____

b. Annual number of procedures with: General Anesthesia: _____ Spinal or Caudal Anesthesia: _____ Other: ______

c. Anesthesia administered by: ______________________________

d. Distance to nearest hospital: ________________

e. Description of life saving equipment/supplies: ______________________

V. COVERAGE INFORMATION

53. Please list your previous professional liability insurance carrier(s) and supply information requested below:

Insurance Company	Policy Limits	Coverage Dates	Type of Policy	Premium	✳ Total # of Claims
		From: To:	☐ Occurrence ☐ Claims Made		
		From: To:	☐ Occurrence ☐ Claims Made		
		From: To:	☐ Occurrence ☐ Claims Made		
		From: To:	☐ Occurrence ☐ Claims Made		

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

54. Have you ever practiced without professional liability insurance? ☐ Yes ☐ No IF YES, specify dates:

55. **Effective Date Desired:** ____________________ **Retroactive Date Desired:** ____________________

__Important__: Declarations Page of your current policy must be attached if a retroactive date is requested. THE COMPANY MAY NOT PROVIDE DESIRED DATES.

56. **Policy Limits Desired:** ☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $1,000,000/$3,000,000 ☐ Other: ______________________

VI. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

This applicant declares, warrants and represents that the information contained in the application is true, complete and accurate and that no material facts have been omitted, suppressed, misstated or concealed.

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, completeness and accuracy of the applicant's representations.

This applicant understands that incorrect, untrue, incomplete or inaccurate information could void coverage.

The applicant requests that this application for insurance coverage be submitted for consideration to GENERAL STAR. Accordingly, the applicant authorizes and directs any person or organization whatsoever to release and furnish to the Company all information requested which may relate to the applicant's insurability. The applicant also consents to the review by the Company of any incidents or occurrences likely to result in a malpractice allegation or claim. The applicant agrees to cooperate in the review of claims which apply to the coverage requested.

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

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

THE APPLICANT UNDERSTANDS THAT COMPLETION OF THIS APPLICATION NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.

> GENERAL STAR INDEMNITY COMPANY is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where GENERAL STAR NATIONAL INSURANCE COMPANY is "non-admitted or "surplus lines"), 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.

Signature: ______________________________ Date: ______________________

General Star Select

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

PHYSICIANS AND SURGEONS CLAIMS-MADE COVERAGE

ADDITIONAL INFORMATION FORM

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

QUESTION #	COMMENTS
	SIGNATURE: DATE: