

RSUI Group, INC.
 945 East Paces Ferry Road,
 Suite 1800
 Atlanta, GA 30326-1125

**APPLICATION FOR PROFESSIONAL
 LIABILITY INSURANCE
 MISCELLANEOUS MEDICAL
 (CLAIMS-MADE FORM)**

1. NAME OF APPLICANT: _____
 (If other than parent firm, supply full details of ownership entity)

2. MAILING ADDRESS: _____
 (If multiple name and locations, please attach list)

PHONE NO. _____

3. a) DATE ESTABLISHED _____ Corp. _____ Partnership _____ Prof. Assoc. _____ Individual _____

b) In what states is the applicant registered and licensed to practice? _____

4. Is the firm engaged in, owned by, associated with or controlled by any other business? _____

If yes, give details _____

5. PROFESSIONAL ACTIVITIES AND SPECIALTY (Attach narrative description if necessary)
 Check One:

- | | |
|---------------------------------------|---------------------------------------|
| _____ Health Maintenance Organization | _____ Residential Healthcare Facility |
| _____ Home Healthcare Agency | _____ Other (Specify) _____ |
| _____ Medical/Testing Laboratory | _____ |
| _____ Nurse's Registry | _____ |
| _____ Out-Patient Clinic | _____ |

6. State approximate division of applicant's patients among:

- | | |
|------------------------------------|----------------------------------|
| a) Alcoholics (%) | k) Obstetrical (%) |
| b) Counseling/Family Planning (%) | l) Pediatric (%) |
| c) Communicable (%) | m) Psychiatric (%) |
| d) Dental (%) | n) Research or Experimental (%) |
| e) Drug Addicts (%) | o) Senile or Aged (%) |
| f) General (%) | p) Stress Testing (%) |
| g) Hemodialysis (%) | q) Surgical (%) |
| h) Holistic Medicine (%) | r) Tubercular (%) |
| i) Medical (%) | s) Other _____ (%) |
| j) Mentally Retarded (%) | |

7. a. List the number and type of applicant's employees and volunteers: If None State None.

NUMBER	Type of Profession	NUMBER	Type of Profession
a) _____	Inhalation Therapists	i) _____	Perfusionists
b) _____	Laboratory Technicians	j) _____	Pharmacists
c) _____	Nurse Anesthetists	k) _____	Physicians – Minor Surgery
d) _____	Nurses, Licensed Practical	l) _____	Physicians – No Surgery
e) _____	Nurse Practitioner	m) _____	Physiotherapists
f) _____	Nurses Registered	n) _____	Social Workers
g) _____	Opticians	o) _____	Speech Therapists
h) _____	Optometrists	p) _____	Other

b. List the number and type of independent contractors who provide professional services on behalf of the applicant.

IF NONE, STATE NONE. _____

C. Are all the above individuals licensed in accordance with applicable state and federal regulations? ___ Yes ___ No
If no, attach explanation.

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the above employees:

- | | YES | NO |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------|
| a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? | a) _____ | _____ |
| b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? | b) _____ | _____ |
| c) Ever been treated for alcoholism or drug addiction? | c) _____ | _____ |
| d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? | d) _____ | _____ |

8. Does the applicant perform:
- | | YES | NO |
|----------------------------------------------------------------------------------------|----------|-------|
| A. Acupuncture or acupuncture anesthesia? Explain: _____ | A. _____ | _____ |
| B. Angiography/Arteriography/Venography? Describe: _____ | B. _____ | _____ |
| C. Catheterization (other than urinary or umbilical)?
Describe procedure: _____ | C. _____ | _____ |
| D. Closed reduction of compound fractures and/or Normal Deliveries and/or Demabrasion? | D. _____ | _____ |
| E. Injection of radioisotopes and/or use of irradiated substances?
Describe: _____ | E. _____ | _____ |
| F. Radiation Therapy and/or Chemotherapy? Describe: _____ | F. _____ | _____ |
| G. Psychiatric shock therapy? | G. _____ | _____ |
| H. Silicone Injections/ Describe: _____ | H. _____ | _____ |
| I. Spinal Anesthesia (other than saddle blocks or caudals)? | I. _____ | _____ |
| J. Laser treatment? Describe: _____ | J. _____ | _____ |

9. Does the applicant perform any:
- | | | |
|------------------------------------------------------------------------------------------------------------------------------------|----------|-------|
| A. Surgery other than incision of superficial boils or suturing superficial fascia? | A. _____ | _____ |
| B. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? | B. _____ | _____ |
| C. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections? | C. _____ | _____ |
| D. Cosmetic Plastic Surgery? Describe: _____ | D. _____ | _____ |
| E. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? | E. _____ | _____ |
| F. Hysterectomies? | F. _____ | _____ |
| G. Open reduction of fractures? Describe: _____ | G. _____ | _____ |
| H. Surgery for weight reduction of patients? | H. _____ | _____ |
| I. Abortions and/or menstrual extractions? Describe (include trimester, method and number of Abortions performed per month): _____ | I. _____ | _____ |
| J. Silicone Implants? Describe: _____ | J. _____ | _____ |
| K. Sterilization Procedures? Describe: _____ | K. _____ | _____ |
| L. Biopsies and/or endoscopies? List types performed: _____ | L. _____ | _____ |
| M. Sex change operations? Describe and advise the number performed per year: _____ | M. _____ | _____ |
| N. Other Surgery? Describe: _____ | N. _____ | _____ |

10. Does the applicant perform hospital emergency room care?
a) for its own regular patients? ___ Yes ___ No b) for patients not its own? ___ Yes ___ No
c) If answer to (b) is yes, please specify: the percentage of its time devoted to this work = ___%, the number of hours per month devoted to this work = ___ hrs.

11. Does the applicant use drugs for weight reduction of patients? ___ Yes ___ No If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant.

12. Does the applicant administer any methadone treatment? Yes No If yes, describe treatment and controls used and indicate number of treatments during last 12 months _____ Next 12 months _____
13. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes No If yes, attach detailed explanation.
14. Does the applicant maintain any beds for overnight occupancy? Yes No If yes, total number: _____
15. State number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. Ste by whom treatment is given and number of procedures: _____

16. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes No If yes, give details, including name, location, size and number of beds. _____

17. State sources and amounts of total revenue:

Source	Amount Last Policy Year	Ext. Amount This Policy Year
A. Charitable Contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee for Services	\$ _____	\$ _____
D. _____	\$ _____	\$ _____
E. _____	\$ _____	\$ _____
TOTAL GROSS REVENUE:	\$ _____	\$ _____

18. Number of patient encounters last 12 months _____ and/or patient test carried out _____
(NOTE: "Patient encounters" refers to number of visits – not number of patients.)

19. Number of estimated patient encounters next 12 months _____ and/or patient tests carried out _____
(NOTE: "Patient encounters" refers to number of visits – not number of patients.)

20. If applicant has a training school, complete the following.

Specify profession for which students are being trained	Max. No. of students per session	No. of sessions per year	% of Time involved in clinical setting	Number of students	Qualifications of faculty (eg. MD, RN, PHD)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

21. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

22. Is the Applicant currently insured under a Commercial General Liability Policy? Yes No If yes, please give details:

Insurance Company	Type of Coverage	BI	Limits	PD	From	To
_____	_____	_____	_____	_____	_____	_____

23. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?
_____ Yes _____ No If yes, please give details: _____

24. Has any claim ever been made against the firm or any of its employees? Yes _____ No _____ If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

25. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? Yes _____ No _____ If yes, please give full details on the same basis as item 24.

26. Has any insurer cancelled or refused to renew any similar insurance during the past five years? _____

27. Limits of Liability requested _____ Deductible _____

28. Desired term of policy: From _____ To _____

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Date

Signature of Applicant

Title

Producer