

Gulf Atlantic Legal Defense Insurance, Inc.

2549 Barrington Circle (32308) P.O. Box 12200, Tallahassee, FL 32317-2200

Agent

APPLICATION FOR LEGAL EXPENSE INSURANCE

All answers should reflect your anticipated practice for the next 12 months.

This is an application for a **Legal Expense Insurance Policy**. Coverage under this policy only reimburses You for certain attorneys' fees and other expenses as defined in the policy ("**Defense Costs**") which arise as a result of a medical malpractice Claim made against You. **This policy does not cover You for settlements, judgments, awards or any other form of damages ("**Damages**") for which You may become obligated as a result of a medical malpractice Claim.** The policy also does not cover legal expenses or attorneys' fees incurred by any injured person, or for Defense Costs incurred by or on behalf of any person other than You in defense of a claim.

As used in this Application, "**Claim**" means notice to you of an actual, threatened, or possible demand for money or services arising out of your professional services. A claim includes any medical incident or other situation which you believe may result in a demand being made against you, including, but not limited to, a patient complaint, poor or unexpected results, an attorney's request for medical records or a lawsuit; "**Medical Incident**" means any act, error or omission in providing of or failure to provide professional services by you. This includes your responsibility for anyone acting under your direction or control.

In order for You to be covered under this policy for Defense Costs arising out a Claim against You, the Claim must arise from Medical Incidents or events which occurred after the policy's retroactive date and which are first made against You and reported to the company while this policy is in force.

Coverage is subject to underwriting approval and payment of the initial premium. No coverage exists until the initial premium has been received and a binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured or their Agent.

Please complete the following in ink and answer all questions in full. If a question does not apply, state "none" or "N/A." You may attach pages if you need additional space to completely respond to a question. Please include a copy of your letterhead and all your advertisements, along with a copy of your **curriculum vitae** with this application.

GENERAL INFORMATION			
Name			
Address			
City	County	State	Zip
Medical License No(s)	Licensed State(s)	DEA License No.	
Date of Birth: / /	Social Security No.	Home Phone No.	
Office Phone No.	Fax No.	E-mail Address	

POLICY INFORMATION	
Date you desire coverage to begin / /	First practice date / /
Do you desire Prior Acts coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes — retroactive date requested: (If yes, Prior Acts form MUST be completed) Note: If no retroactive date is requested, we will quote the policy with NO PRIOR ACTS COVERAGE.	
Limits of Liability Requested: <input type="checkbox"/> \$100,000 / 200,000	

PRACTICE INFORMATION					
Does the address provided above represent the only location / facility at which you provide professional services? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO , please provide the name, address and phone / fax numbers for each.					
Your Practice Specialty					
Subspecialty					
Type of Practice <input type="checkbox"/> Private <input type="checkbox"/> Hospital <input type="checkbox"/> Group <input type="checkbox"/> Clinic <input type="checkbox"/> Other:					
Indicate procedures for which you are the (P) PRIMARY physician or for which you (A) ASSIST. Leave blank any procedures which you do not perform.					
Procedure	P	A	Procedure	P	A
Admin. of General Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Fractures - Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Angiography	<input type="checkbox"/>	<input type="checkbox"/>	Impotency Therapies	<input type="checkbox"/>	<input type="checkbox"/>
Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Insertion of IUD's	<input type="checkbox"/>	<input type="checkbox"/>
Assist in Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Invasive Radiology	<input type="checkbox"/>	<input type="checkbox"/>
Chelation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Facial Peels	<input type="checkbox"/>	<input type="checkbox"/>	Laser Surgery/Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	Liposuction	<input type="checkbox"/>	<input type="checkbox"/>
D&C's	<input type="checkbox"/>	<input type="checkbox"/>	Liver Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
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Procedure	P	A	Procedure	P	A	Procedure	P	A
Elective cosmetic surgery/Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Neonatology	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomies	<input type="checkbox"/>	<input type="checkbox"/>
			Neurologic surgery	<input type="checkbox"/>	<input type="checkbox"/>	X-Rays (in office)	<input type="checkbox"/>	<input type="checkbox"/>
Electroshock Therapy _____	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics (# _____)	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss Control using Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Room - Hrs/Wk _____	<input type="checkbox"/>	<input type="checkbox"/>	Ophthalmology	<input type="checkbox"/>	<input type="checkbox"/>			
			Orthopedic Surgery	<input type="checkbox"/>	<input type="checkbox"/>			

Yes	No	1. Do you perform any other invasive procedures or surgeries not listed above? If YES , list each, number performed annually and where performed.
Yes	No	2. Are you Board Certified? If YES , Name of Board: _____ If NO , are you Board Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Yes	No	3. If Board Eligible, have you tested? If YES , how many times have you tested? Written _____ Oral _____
Yes	No	4. Do you participate in the practice of telemedicine (an exchange of opinion or diagnosis via electronic equipment)?
Yes	No	5. Do you have staff membership / privileges at a hospital? If YES , provide name, address and type of privileges; if NO , explain why and what arrangements you have made to admit patients.

INSURANCE INFORMATION

IMPORTANT NOTE TO APPLICANTS HAVING A PRIOR CLAIMS-MADE INSURANCE POLICY:

Unless you are purchasing Tail Coverage your expiring insurance policy, you will not be covered under that expiring policy for Claims which first arise after that policy's termination date. *The Gulf Atlantic policy for which You are now applying does not provide coverage for Damages. It is a legal expense only policy.* If You are leaving a claims-made insurance policy which provides indemnity coverage for Damages, we strongly urge You to review the reporting requirements of Your expiring policy and to report any Medical Incidents which reasonably could result in a Claim (to the extent permitted by that policy) before it terminates.

Yes	No	6. Are you currently covered for medical professional liability coverage? If YES , please attach a copy of your current Declarations page.
Yes	No	7. Has your professional liability insurance application/coverage ever been canceled, non-renewed or issued on special terms? If YES , please describe.
Yes	No	8. Have you ever been treated for, or have you ever had any problem with, drug or alcohol use? (This includes any charges of DUI, whether or not you were convicted.) If YES , please describe, including any and all treatments, hospitalizations and the current status.
Yes	No	9. Have you ever been treated for, or have you ever had, any emotional or behavioral problem or illness? If YES , please describe, including all treatments, hospitalizations and the current status.
Yes	No	10. Have you ever been charged with a crime other than a minor traffic violation? If YES , please explain.
Yes	No	11. Has your license to practice, authority to prescribe drugs, or hospital privileges ever been restricted, suspended, revoked, acted upon, or non-renewed in any state? If YES , please explain.
Yes	No	12. Do you treat patients participating in an: <ul style="list-style-type: none"> <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other Managed Care Program (describe) _____ A. What percentage of your practice time is spent with these patients? _____ B. What other responsibilities do you have with the managed care program? _____ C. Are you an employee under an "at Risk Contract"? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , what percentage of this is your practice? _____ % Are physician referrals, fees and hospital expenses included in your fees? <input type="checkbox"/> Yes <input type="checkbox"/> No

PARTNERSHIP/CORPORATION/PROFESSIONAL ASSOCIATION INFORMATION

13. Do you practice as part of or with a:

- sole proprietorship professional association solo P.A.
 corporation limited liability partnership Other (describe)

If the answer to any of the above is yes, provide the legal name of the entity or practice:

Yes	No	14. Are you an owner of the entity described above? If YES , describe your ownership interest.
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Yes	No	15. Are you <input type="checkbox"/> employed by or <input type="checkbox"/> under contract to the entity described above? If NO , describe your relationship with the entity.
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Yes	No	16. Do you share office space with any physician not employed by or contracted to the entity? If YES , please describe.
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Yes	No	17. Do you, or does the entity described above, employ, contract with or supervise any physician other than you, any CRNA, PA-C, ARNP or other medical professionals of this nature?
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Would you like to cover yourself for Claims arising out of your vicarious liability for those persons? Yes No

If so, please provide us with the names, specialties and curriculum vitae of each of these persons. **Proof of their insurance is also necessary for us to underwrite this coverage.**

EDUCATION

18. This portion of the application must be completed in full OR a current Curriculum Vitae must accompany this application.

Medical School Name City/State/Country	Degree	Date Obtained
Internship Name City/State	Type	Dates
Residency Name City/State	Type	Dates
Fellowship Name City/State	Type	Dates
Other Training Name City/State	Type	Dates

Are you a graduate of a non-US medical school? Yes No Name:

If you are a graduate of a non-US medical school, are you certified by the Educational Council for Foreign Medical School Graduates ?
 Yes No If **NO**, please explain.

CLAIMS INFORMATION

Yes	No	19. Do you have any Claims or Medical Incidents which you have reported to your current or prior insurance carriers? If YES , please describe in detail all claims, medical incidents or other items which you have reported to your current or prior carriers and their status. (Please complete the attached claim form or provide us with a written statement.)
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Yes	No	20. Are you aware of any Claims or potential Claims that have not been reported to your current or prior insurance carriers? If YES , please explain.
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Yes	No	21. Are you aware of any Medical Incidents involving you or someone under your direction or control which have not been reported to your current or prior insurance carriers? If YES , please explain.

SUPPLEMENTAL WAIVER / RELEASE

Any person who knowingly and with intent to injure, defraud or deceive any insurer files any statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I hereby certify that the above statements, representations and responses are true, complete and correct, and I understand and agree that you will rely on such statements, representations and responses in making a decision as to whether to issue a policy to me. If the answers contained in the application or this certification materially change during any policy period, I agree to immediately notify you. If transmitted to Gulf Atlantic by facsimile, I agree that the facsimile copy of this application received by Gulf Atlantic shall be, and shall have the same effect for all purposes, as the original. I hereby authorize any person or organization, including attorneys who now or in the past have represented me, to release to Gulf Atlantic any and all information, whether privileged or not, relating to my employment, education, training, hospital privileges (whether granted or not), my malpractice insurance (including but not limited to the underwriting and claims files of any present or former malpractice carrier insuring me), and any and all information which Gulf Atlantic may reasonably request to assist it in underwriting my application for insurance or in administering any claim made against me under my Gulf Atlantic policy.

By signing below, I hereby acknowledge on behalf of myself and all applicants:

1. That Gulf Atlantic Legal Defense Insurance, Inc. is a legal expense insurance company under Chapter 642, Florida Statutes, and that the policy I am applying for is a legal expense policy ONLY.
2. That the policy I am applying for does not provide indemnity coverage for damages arising from medical malpractice claims, and only provides reimbursement for those legal expenses outlined in the policy.
3. That the policy I am applying for does not meet the physician financial responsibility requirements as outlined in Section 458.320, Florida Statutes, and that I (or we) must separately comply with the provisions of that Section.

PLEASE ATTACH ALL REQUESTED ITEMS TO THIS APPLICATION.

Agent Signature	Applicant Signature
Agent License No.	Date

Please include a copy of your letterhead and curriculum vitae with this application.