

ANESTHESIOLOGY



PHYSICIANS
B·E·N·E·F·I·T
ALLIANCE
AN ASSOCIATION

15 Peters Canyon Road • Irvine • CA • 92606
Phone: 714/436-6400 or 800/748-6293 • Fax: 714/436-6499

APPLICATION FOR COMPREHENSIVE
PROTECTION PROGRAM

Underwritten By



IMPORTANT
PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION

IMPORTANT — PLEASE READ CAREFULLY

SIGNATURE

After completing the application, your signature and the date are required on Page 14. Please be sure to date the signature. You must answer each question. INCOMPLETE APPLICATIONS WILL BE SUBJECT TO DECLINATION.

CLAIMS INFORMATION

If you have any claims, suits, or incidents alleging malpractice brought against you within the past ten (10) years, COMPLETE A SUPPLEMENTAL CLAIM INFORMATION SHEET FOR EACH CLAIM, PAGE 13. Please provide sufficient information for the underwriters to evaluate the medical aspects of the case, specifically relating to the treatment which you rendered. Each Supplemental Claim Information sheet completed must be signed and dated.

RETROACTIVE COVERAGE

Retroactive coverage provides coverage for claims which are first made against you after the effective date of coverage with American Healthcare Indemnity Company, arising out of your acts or omissions prior to the effective date of such coverage. Retroactive coverage is only available for professional liability claims; the business liability, medical payments, and employee benefit programs liability coverages are written on an "occurrence" basis and only cover occurrences which happen during the policy period, regardless of when the claim is made and reported to American Healthcare Indemnity Company. If you do not obtain retroactive coverage, you will have no coverage from American Healthcare Indemnity Company for such claims arising out of these acts or omissions. Retroactive coverage is subject to underwriting approval. **IF YOU DESIRE TO OBTAIN RETROACTIVE COVERAGE, A COPY OF YOUR MOST RECENT DECLARATIONS PAGE FROM YOUR PRESENT CARRIER INDICATING THE ORIGINAL EFFECTIVE DATE OF COVERAGE AND A CURRENT PAID THROUGH DATE MUST BE ATTACHED.**

Managed By



SCHWEICKERT & COMPANY
INSURANCE AGENTS, BROKERS & MANAGERS

3090 Bristol Street, Suite 160 Costa Mesa, CA 92626



The undersigned hereby applies to American Healthcare Indemnity Company (the "Company") for Professional Liability Insurance Coverage according to the terms and conditions of its policy of Physicians Professional Liability Insurance Claims Made Form, CPP-90 or CPP-91.

If I am practicing (i) as an individual practitioner (ii) as the sole shareholder of a professional medical/dental corporation or (iii) as an employee of an individual practitioner or a solo professional medical/dental corporation, I am hereby applying to become a "physician member" under a CPP-91 policy to be issued by the Company. If I am practicing (i) as a member or employee of a professional medical/dental partnership or (ii) as a shareholder, employee, officer, or director of a professional medical/dental corporation which may have more than one shareholder, I am applying hereby to become a "physician member" under a CPP-90 policy issued or to be issued by the Company to such partnership or corporation as the "named insured."

I UNDERSTAND THAT THE PROFESSIONAL LIABILITY, PROFESSIONAL COMMITTEE ACTIVITIES AND LEGAL DEFENSE REIMBURSEMENT FOR STATE LICENSING AUTHORITY PROCEEDINGS ONLY IS "CLAIMS MADE AND REPORTED" COVERAGE AND THAT THE POLICY DOES NOT PROVIDE COVERAGE FOR THOSE CLAIMS AGAINST A PHYSICIAN MEMBER (FOR HIS OR HER ACTS OR OMISSIONS) WHICH ARE FIRST REPORTED TO THE COMPANY AFTER TERMINATION OF THE PHYSICIAN MEMBERS' "CERTIFICATE PERIOD" AS DEFINED IN THE POLICY.

I further understand that, unless I obtain retroactive coverage from the Company, the policy does not provide coverage for claims reported to the Company during the coverage period relating to or arising out of incidents occurring prior to the effective date of coverage of a physician member.

OFFICE USE ONLY

Account No. 0000000000

Policy No. 0000000000

Group No. 0000000000

Renewal Application

New Application

DATE RECEIVED

SECTION I — PERSONAL INFORMATION

1. Entity As Named Insured _____

2. Office Street Address _____

City _____ County _____ State _____ Zip _____

3. Leased/Rented Owned Approximate Square Footage _____

LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 12.

4. Phone Number (_____) _____ Fax Number (_____) _____

5. E-Mail Address _____

6. Your Full Legal Name (individual) _____

7. Mailing Address (if different from office address)

City _____ County _____ State _____ Zip _____

8. Resident Address

City _____ County _____ State _____ Zip _____

9. Phone Number (_____) _____ Fax Number (_____) _____

10. Taxpayer I.D. Number _____ or Social Security Number _____

11. Date of Birth ___/___/___ Place of Birth _____ Male Female

12. Effective Date Desired ___/___/___ Professional Liability Retroactive Date Desired ___/___/___

**Business liability coverages are written on an "occurrence" basis and retroactive coverage is not available for these coverages.*

13. Desired Limits of Liability

\$1,000,000 Per Claim/\$3,000,000 Annual Aggregate

\$2,000,000 Per Claim/\$4,000,000 Annual Aggregate

\$5,000,000 Per Claim/\$5,000,000 Annual Aggregate

14. Are you American Board certified in your specialty? Yes No

IF YES, PLEASE LIST THE NAME(S) OF AMERICAN SPECIALTY BOARD(S):

15. Are you licensed by the state in which you now practice? Yes No

IF YES:

Federal DEA Number _____

License Number _____

Permanent Temporary

16. Are you licensed in any other state? Yes No

IF YES, PLEASE LIST THE STATE(S) AND LICENSE NUMBER(S) USING THE REMARKS SECTION, PAGE 12.

SECTION II — UNDERWRITING INFORMATION

17. If you use a collection agency, does the agency have the authority to file a collection suit at its own discretion? Yes No

18. Has any medical professional liability insurer canceled, declined coverage, refused renewal, or renewed your coverage under restrictive conditions? Yes No

IF YES, PLEASE EXPLAIN USING THE REMARKS SECTION, PAGE 12.

19. Have you ever used any intoxicant, narcotic or psychoactive drug to the extent that it has interfered with your ability to perform professional duties? Yes No

IF YES, PLEASE EXPLAIN USING THE REMARKS SECTION, PAGE 12.

20. Do you have any physical or mental problems which might affect your practice of medicine? Yes No

IF YES, PLEASE EXPLAIN USING THE REMARKS SECTION, PAGE 12.

21. Have you ever been convicted of a felony? Yes No

IF YES, PLEASE EXPLAIN USING THE REMARKS SECTION, PAGE 12.

22. Has any investigation, revocation, suspension, restriction, other disciplinary action, or other change in status occurred with respect to your license to practice, your DEA license, your privileges or participation at any hospital, health maintenance organization, or other medical facility, or your certification by or membership in any medical association, medical society, or medical board? Yes No

IF YES, PLEASE EXPLAIN USING THE REMARKS SECTION, PAGE 12.

23. Has a fee complaint or professional conduct complaint ever been registered against you with your medical association or state or county medical society, State Board of Medical Examiners, or hospital medical staff?

Yes No

IF YES, PLEASE PROVIDE A COPY OF THE COMPLAINT, YOUR ANSWER, AND, IF RESOLVED, THE FINAL RESOLUTION FROM YOUR MEDICAL BOARD. FOR PROFESSIONAL CONDUCT COMPLAINTS, ALSO SUBMIT COPIES OF THE PATIENT CHARTS AND OPERATIVE NOTES IF THESE DOCUMENTS ARE A MATTER OF PUBLIC RECORD.

SECTION III — CLAIM, INCIDENT AND INSURANCE HISTORY

24. a. Have you ever been involved in a malpractice claim, suit or "incident" either directly or indirectly?

Yes No

b. Are you aware of any facts or circumstances which may give rise to a suit or claim in the future?

Yes No

IF YOU RESPONDED YES, TO EITHER OF THE ABOVE, PLEASE COMPLETE A CLAIM INFORMATION SHEET (PAGE 13) FOR EACH CLAIM/CIRCUMSTANCE.

25. List the names of all professional liability insurance carriers which have insured you during the past five (5) years and the dates of such coverage.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE REMARKS SECTION, PAGE 12.

CARRIER	INCEPTION DATE	EXPIRATION DATE	RETROACTIVE DATE (IF CLAIMS MADE)

PLEASE ATTACH A COPY OF THE DECLARATIONS FROM YOUR CURRENT POLICY.

26. If your coverage is currently claims made, do you wish to buy prior acts coverage from the Company to insure you for new, unreported claims arising from services you provided while you were insured with your present carrier?

Yes No

a. If no, do you intend to purchase extended reporting endorsement ("tail") coverage from your present carrier?

Yes No

IF YOU ANSWERED YES TO QUESTION 26a., PLEASE SUBMIT A COPY OF YOUR EXTENDED REPORTING ENDORSEMENT.

SECTION IV — MEDICAL EDUCATION

27. a. **Medical School**

School _____

City _____ State _____

Country _____

Year Graduated _____ Degree _____

b. Internship

Hospital _____

City _____ State _____ From ____/____/____ To ____/____/____
MONTH & YEAR MONTH & YEAR

c. Residency

Hospital _____

City _____ State _____ From ____/____/____ To ____/____/____
MONTH & YEAR MONTH & YEAR

Hospital _____

City _____ State _____ From ____/____/____ To ____/____/____
MONTH & YEAR MONTH & YEAR

d. Fellowship

Fellowship In _____

Hospital _____

City _____ State _____ From ____/____/____ To ____/____/____
MONTH & YEAR MONTH & YEAR

28. Have you met all the legal requirements in your state for continuing medical education? Yes No

IN THE REMARKS SECTION, PAGE 12, PLEASE LIST ALL COURSES TAKEN IN THE LAST TWELVE (12) MONTHS, INCLUDING DATES AND NUMBER OF CME CREDITS, ANY ADDITIONAL TRAINING; WHERE, DATES AND TYPE OF TRAINING. LIST POSTGRADUATE STUDIES AND SPECIALTY SOCIETY MEETINGS.

SECTION V — YOUR PRACTICE

29. List all locations where you have practiced for the last ten (10) years. Of the locations where you now practice, also indicate the average number of hours you practice per week at each location.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE REMARKS SECTION, PAGE 12.

	ADDRESS (STREET, CITY, COUNTY, STATE, AND ZIP)	HOURS PER WEEK
a.	_____	_____

b.	_____	_____

c.	_____	_____

d.	_____	_____

30. List hospitals at which you currently are or have been a staff member for the last five (5) years.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE REMARKS SECTION, PAGE 12.

	HOSPITAL	ADDRESS	COUNTY	TYPES OF PRIVILEGES (ACTIVE, COURTESY, ETC.)	FROM	TO	HRS/ WEEK	% OF NCOMI
3					MO/YR	MO/YR		
3					MO/YR	MO/YR		
3					MO/YR	MO/YR		
3					MO/YR	MO/YR		
3					MO/YR	MO/YR		

31. Are you chief or head of the department? Yes No

IF YES, INDICATE LOCATION NUMBER: _____

32. Do you provide general anesthesia in a surgicenter or other non-hospital facility? Yes No

IF YES, PROVIDE DETAILS INCLUDING ACCREDITATION INFORMATION:

33. Do you limit your practice to anesthesiology? Yes No

IF NO, INDICATE YOUR OTHER SPECIALTY AND PROVIDE DETAILS INCLUDING PERCENTAGE OF PRACTICE DEVOTED TO EACH. IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE REMARKS SECTION, PAGE 12.

34. If a portion of your practice described in question 33. is devoted to pain management:

a. Do you utilize implantation of medical devices? Yes No

IF YES, PLEASE IDENTIFY THE TYPES OF DEVICES, THEIR MANUFACTURERS AND MEDICAL PURPOSE. FOR EACH, PLEASE ALSO INDICATE IF THEY ARE USED FOR BENIGN TREATMENT OF CHRONIC PAIN OR FOR TERMINAL PATIENTS ONLY:

b. Please list techniques used:

35. Give the approximate percentages of your practice dedicated to the following specialties. Where applicable, indicate the split between general and local anesthesia.

SPECIALTY	PERCENTAGE	GENERAL ANESTHESIA	LOCAL ANESTHESIA
Pediatric	%		
Neonatal	%		
OB	%		
Vascular	%		
Open Heart	%		
ICU/CCU Management	%		
Neurosurgery	%		
Pain Management	%		

36. a. List the number and type of professional employees

IF NONE, PLEASE SO STATE _____

PROFESSIONAL EMPLOYEES	NUMBER	TYPE
Physicians (other than yourself)		
Nurse Anesthetists		
Please Provide Names and Titles (i.e. PA, NP, RN, etc.)		

Other (describe)		

b. Are all of the above individuals licensed in accordance with applicable state and federal regulations?

Yes No

IF NO, PLEASE EXPLAIN

37. Do you supervise any individuals who are not your own employees? Yes No

IF YES, PLEASE PROVIDE DETAILS AND INDICATE NUMBER OF NON-EMPLOYED INDIVIDUALS YOU SUPERVISE:

NON-EMPLOYED INDIVIDUALS	NUMBER	DETAILS
Physicians		
Nurse Anesthetists		
Please Provide Names, Titles, and Insurance Carriers		
<hr/>		
<hr/>		
Other (describe)		
<hr/>		
<hr/>		
<hr/>		

38. Are you employed by any corporate or fictitious name entity (i.e., D.B.A.)? Yes No

IF YES, PLEASE PROVIDE NAME:

39. Do you own shares in a professional corporation? Yes No

IF YES, PLEASE PROVIDE THE NAMES OF ALL OTHER SHAREHOLDERS:

40. Do you have any partners? Yes No

IF YES, PLEASE PROVIDE THEIR NAMES:

41. Are you employed by any physicians or surgeons? Yes No

IF YES, PLEASE PROVIDE THEIR NAMES:

42. Do you have any associates? Yes No

IF YES, PLEASE PROVIDE THEIR NAMES:

PLEASE PROVIDE THE EXTENT OF YOUR ASSOCIATION (PLEASE CHECK ONE):

- | | |
|------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Share Office | <input type="checkbox"/> Independent Contractor |
| <input type="checkbox"/> Common Billings | <input type="checkbox"/> Share Calls |
| <input type="checkbox"/> Share Employees | <input type="checkbox"/> Other (specify below) |
-

43. **Please attach a copy of your office letterhead and billing statements.**

44. Do you advertise (other than a general yellow pages listing)? Yes No

IF YES, PLEASE SUBMIT COPIES OF PRINT, AUDIO (I.E., RADIO) AND VIDEO (I.E., TELEVISION) ADVERTISING CURRENTLY USED.

SECTION VI — PROCEDURES

45. a. On average, how many hours per day and days per week do you practice?

Hours Per Day _____

Days Per Week _____

b. Of the above, how many hours per day and days per week are devoted to direct patient care?

Hours Per Day _____

Days Per Week _____

c. Of the above, how many hours per day and days per week are devoted to related administrative activities?

Hours Per Day _____

Days Per Week _____

d. What is your average weekly patient load? _____

i. Of this number, how many require general anesthesia? _____

46. Do you perform acupuncture anesthesia? Yes No

IF YES, PLEASE PROVIDE DETAILS:

47. During all general anesthesia, do you use a pulse oximeter monitor? Yes No

IF NO, PLEASE EXPLAIN:

48. During all general anesthesia:

a. Is an electrocardiogram continuously displayed? Yes No

IF NO, PLEASE EXPLAIN:

b. How often is arterial blood pressure determined and evaluated? Every _____ minutes.

c. How often is heart rate determined and evaluated? _____

d. How is circulatory function evaluated? _____

49. During all general anesthesia, do you use an end tidal CO₂ monitor? Yes No

IF NO, PLEASE EXPLAIN:

50. During all general anesthesia using an anesthesia machine, do you:

a. Use an oxygen analyzer with a low concentration limit alarm? Yes No

IF NO, PLEASE EXPLAIN:

b. Test proper functioning alarm prior to each use? Yes No

IF NO, PLEASE EXPLAIN:

51. When ventilation is controlled by a mechanical ventilator, do you:

a. Use a device equipped with a full set of safety alarms? Yes No

IF NO, PLEASE EXPLAIN:

b. Test proper functioning alarms prior to each use? Yes No

IF NO, PLEASE EXPLAIN:

52. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? Yes No

IF NO, PLEASE EXPLAIN:

53. Do you personally own an anesthesia machine? Yes No

a. Who is responsible for maintaining the machine? _____

b. How often is the machine serviced? _____

54. Do you perform and document equipment checks on all anesthesia equipment prior to use? Yes No

55. Is a pre-surgery anesthesia evaluation performed on all patients and documented prior to anesthesia induction? Yes No

SECTION VII — OTHER PROFESSIONAL DUTIES

56. a. Are you associated in any capacity with any facility designated for or providing any emergency care? Yes No

IF YES, PLEASE GIVE FULL LEGAL NAME AND LOCATION OF FACILITY(IES), AS WELL AS ANY DEPARTMENT IN WHICH YOU SERVE:

b. Is insurance coverage provided for your work by the facility? Yes No

c. Is your work at this facility:

i. On your own patients only? Yes No

ii. Required for staff privileges? Yes No

iii. Are any of the above on a fee basis? Yes No

iv. Other? Yes No

IF YES, PLEASE DESCRIBE:

SECTION VIII — OPTIONAL EXCESS PERSONAL LIABILITY COVERAGE (\$1,000,000 Per Occurrence)

This coverage provides personal liability protection for claims arising out of personal injury or property damage occurring during the insured's policy period or coverage period. This coverage is excess over and above the required underlying limits listed below, and does not apply to personal injury or property damage claims arising out of business or professional pursuits of the insured.

57. Do you desire this coverage? Yes No

IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

a. Do you maintain the following minimum limits of liability on underlying policies? Yes No

IF NO, YOU MUST INCREASE YOUR LIMITS TO THOSE INDICATED BELOW BEFORE COVERAGE MAY BE ADDED.

i. AUTOMOBILE LIABILITY: \$100,000/\$300,000 Bodily Injury \$25,000 Property Damage or Combined Single Limit of \$300,000 Yes No

ii. COMPREHENSIVE PERSONAL LIABILITY: \$50,000 (Often found in Section II of Homeowner's Policy) Yes No

iii. Do you own, lease, rent, or regularly use watercraft twenty-six feet (26') or more in length? Yes No

IF YES, DO YOU MAINTAIN \$100,000 WATERCRAFT LIABILITY COVERAGE? Yes No

b. During the past three years, has any insurance company canceled, declined coverage, or refused renewal of any similar Excess Personal Liability Insurance? Yes No



PHYSICIANS
B·E·N·E·F·I·T
ALLIANCE
AN ASSOCIATION

3090 Bristol Street • Suite 160 • Costa Mesa • CA • 92626
Phone: 714/436-6400 or 800/748-6293 • Fax: 714/436-6499

**SUPPLEMENTAL
CLAIMS INFORMATION**

(Please use photocopies of this form for each additional claim.)

1. Name, age, and sex of patient _____

 2. Date of first consultation _____
 3. Physical condition and diagnosis at above date _____
 4. Dates of treatment given and nature of same _____

 5. Date of claim, and allegations made against you _____

 6. Disposition of claim, amount of judgment or settlement _____
 Open Claim – Reserve \$ _____ Settlement, or
 Closed Claim – Loss \$ _____ Date Closed ____/____/____ Judgment
 7. What insurance company, if any, was involved? _____ Policy No. _____
 8. Subsequent condition of health of patient _____

 9. Names of other doctors, if any, involved in the claim or suit _____

 10. To whom may we refer for further information about the suit? _____

- Please type or print name: _____ Policy No. _____

X _____
(DATE COMPLETED)

X _____
(SIGNATURE OF APPLICANT)

SECTION X — SIGNATURE

THIS IS THE SIGNATURE SECTION TO THE APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE FOR ALL PHYSICIANS.

REPRESENTATIONS AND AUTHORIZATIONS OF APPLICANT

I hereby request that my application for insurance coverage through the Physicians Benefit Alliance Risk Purchasing Group be submitted for consideration to American Healthcare Indemnity Company.

I authorize the release and exchange of information involving past and future underwriting and claims matters between the Company and my present and any past professional associations/societies, the county medical association/society in any county in which I practice(d), their committees and insurance consultants, any hospital with which I presently or previously held staff privileges, any prior insurance companies and any state medical licensing board or other governmental agency. I authorize the Company to forward Evidence of Insurance to the Emergency Departments/Hospitals/Health Plans who provide my signed authorization to do so in the future.

I agree that the Company and, to the extent requested by the Company and/or any other authorized representatives of the Company, may participate in the processing and review of this application, of any future information submitted and of any matter relating to any incidents or claims of alleged medical malpractice while I am insured by the Company.

I also agree that if requested by the Company, I will promptly submit a Request for Information Disclosure form to The National Practitioner Data Bank requesting a Self-Query, and will forward the full results of such query to the Company immediately upon my receipt thereof for inclusion in this application for insurance.

If I become a physician member under a policy issued by the Company to a partnership or corporation (as "named insured"), I irrevocably authorize and designate the medical/dental partnership or medical corporation, of which I am a member, officer, director or employee to act on my behalf and as my agent in all respects (including, without limitations, the payment of premiums, and the receipt of refunds thereof, and the receiving and giving of notices of all types) relating to the insurance for which I am applying. This authorization and designation shall remain in effect for so long as such partnership or corporation is a named insured under an insurance policy issued by the Company and I am a certificate holder under such policy.

American Healthcare Indemnity Company insurance policies written through the Physicians Benefit Alliance Program expire each year on January 1 at 12:01 a.m. and changes in premiums and other policy terms are generally made at that time. If a policy is first issued after the first day of a calendar year, such changes in premium terms may be made at the following January 1 only if the insured requests a policy term of less than one (1) year.

THE APPLICANT HEREBY REQUESTS THAT AMERICAN HEALTHCARE INDEMNITY COMPANY ISSUE THE POLICY FOR A TERM EXPIRING AT 12:01 A.M. ON JANUARY 1 NEXT FOLLOWING THE DATE OF THIS APPLICATION. THE APPLICANT UNDERSTANDS THAT PREMIUMS WILL BE PAYABLE QUARTERLY.

I HEREBY REPRESENT THAT THE STATEMENTS AND ANSWERS MADE WITHIN THIS APPLICATION ARE FULL, COMPLETE AND TRUE. ALSO, I UNDERSTAND THAT THIS IS NOT A BINDER OF INSURANCE, BUT IS INSTEAD AN APPLICATION FOR INSURANCE, AND THAT IT IS SUBJECT TO UNDERWRITING REVIEW AND APPROVAL.

Name of Applicant (Please type or print name)

Signature of Applicant (Please sign your name)

Address

City State Zip

Date