APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION

For Physicians & Surgeons

APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

APPLICATION INSTRUCTIONS & CHECKLIST

We would like to thank you for taking the time to apply to Applied Medico-Legal Solutions Risk Retention Group, Inc. (AMS RRG). You are joining physicians across the country that have helped AMS RRG grow into one of the most successful medical liability insurance risk retention groups. Below, is a checklist which will help you in completing our application.

- ☐ **All questions must be answered. Write in, "I do not know," if necessary.**
- ☐ **The Supplemental Information Worksheet is available to provide any additional information requested, or to better explain you're answers.**
- ☐ **A "Loss Run" from your current and prior carriers covering the last 15 years. Please complete a separate claim worksheet for each reported claim as thoroughly as possible providing brief narrative description of each claim.**
- ☐ **A "No Known Loss" Letter, attached to this application.**
- ☐ **Please enclose a copy of the following with your application:**
  - ☐ **Current Declarations for Professional Liability Insurance**
  - ☐ **Curriculum Vitae**
  - ☐ **Medical and DEA Licenses**
  - ☐ **Purchased Extended Reporting Endorsements**
  - ☐ **Practice letterhead for each location you practice**
  - ☐ **Advertising material you have been using**

INSURANCE NOTICE

Insurance coverage is subject to underwriting approval and payment of the initial premium. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any applicable endorsements, has been issued to the named insured. This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services, and B) are first made against you and are reported to the company while the policy is in force.

APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

GENERAL INFORMATION

First Name	Last Name	Middle Name	Suffix (Jr./Sr.)	Title (MD/DO)

Social Security Number	Date of Birth	Female	Male
- -	/ /	☐	☐

Office Phone Number	Cell Phone Number	Home Phone Number
( ) -	( ) -	( ) -

Fax Number	Practice Web Site Address	E-Mail Address
( ) -		

PRIMARY PRACTICE STREET ADDRESS	Bldg./Suite

County	City	State	Zip Code

Number of years at current location:	
Percentage of your practice at this location:	
Please indicate the Counties where you practice:	
Please enter the formal name of your Partnership, Corporation or Employer:	

NOTE: If coverage for the entity is desired, complete corporate section on page 7 of the application.

INSURANCE COVERAGE SECTION

Current Policy Expires	Requested Effective Date	Requested Retroactive Date
/ /	/ /	/ /

Please indicate your Primary Specialty of Practice:	
If joining a group insured with AMS RRG, indicate name or AMS RRG policy number:	

Limits of Liability you are requesting:	
☐ **$100,000 /$300,000**	☐ **$500,000/$1,500,000 (PA Only – Enrolled in PCF)**
☐ **$200,000/$600,000**	☐ **$1,300,000/$3,900,000 (NY Only)**
☐ **$250,000/$750,000**	☐ **$2,300,000/$6,900,000 (NY Only)**
☐ **$500,000/$1,500,000**	☐ **$$2,500,000/$7,500,000 (VA Only -** Per statutory maximum Code of VA Sec 8.01-581.15**)**
☐ **$1,000,000/$3,000,000**	☐ **$2,000,000/$6,000,000**
Indicate the Limits of Liability you are currently carrying. **(If you are carrying different limits of liability than what you are requesting, please provide explanation on the Supplemental Information Worksheet).**	

Per Claim Deductible (Please select one):			
☐ **None**	☐ **$10,000**	☐ **$50,000**	☐ **$150,000**
☐ **$5,000**	☐ **$25,000**	☐ **$100,000**	☐ **Other →**
If applicable, please check one:		☐ **Indemnity and Defense** ☐ **Indemnity Only**	

NOTE: For any deductible requested in an amount greater than $50,000, a Letter of Credit may be required.

PRIOR ACTS COVERAGE (RETROACTIVE COVERAGE)

A claims-made policy covers claims resulting from medical professional services provided or withheld on or after the retroactive date shown on the policy and first reported while the policy is in force. If your current policy or any previous policies are claims-made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage) from that carrier, there will be NO COVERAGE for any claim arising from any act or omission that took place during that period of claims-made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims-made policy. Retroactive coverage insures claims made against you for incidents that took place while your previous claims-made insurance was in effect, but that were not brought to your attention until after the effective date of the AMS RRG policy. Retroactive coverage does NOT cover claims filed against you and/or reported to the previous insurers prior to the effective date of the policy with AMS RRG. Any claims and all conduct, circumstances, or incidents that could reasonably be expected to result in a claim must be reported to your present carrier prior to the requested effective date of this insurance.

I have read and understand the above statement.

_____ **SIGNATURE**

_____/_____/_____ **DATE (MM/DD/YY)**

Did you purchase an extended reporting endorsement (tail coverage) from your current carrier?	☐ **Yes** ☐ **No**
If NO, do you wish to purchase retroactive coverage from AMS RRG?	☐ **Yes** ☐ **No**

BOARD CERTIFICATION

Are you currently Board Certified?	☐ Yes ☐ No

If Yes, please describe your Board Certification Status Below – Use the Supplemental Information Worksheet if needed

Name of Board	Status Cert.	Status Elig.	Date Certified	Dates Expires	Date Eligibility Expires
			/ /	/ /	/ /
			/ /	/ /	/ /
			/ /	/ /	/ /

If you are NOT Board Certified, please answer the following questions:

I am awaiting results of my most recent exam:	☐ Yes ☐ No
I have taken Part 1 of the exam and have qualified to take part 2:	☐ Yes ☐ No
I am planning to take the Boards on the following date:	/ /
I am not planning on taking any further Board Examinations:	☐ Yes ☐ No

EDUCATION

Medical School Attended	Location	Degree	Date Graduated
Name of Internship Program	**Location**	**Specialty**	**Dates Attended**
Name of Residency Program	**Location**	**Specialty**	**Dates Attended**
Name of Fellowship Program	**Location**	**Specialty**	**Dates Attended**

Please explain any additional years spent in any training programs:

Please explain any gaps in training from medical school to completion of your training:

If you are a graduate of a non-U.S. medical school, are you certified by the Educational Council for Foreign Medical School Graduates?	☐ Yes ☐ No ☐ N/A

Please specify states where you are or have been licensed:

State	Year	License #	Permanent	Temporary	Status

NOTE: If any of your licenses are or have been inactive, suspended, restricted or revoked, please explain on the Supplemental Information Worksheet.

STAFF PRIVILEGES

List all facilities, including non-hospital facilities, where you have staff privileges, listing the principal location first. Please use the Supplemental Information Worksheet if necessary.				
Facility	**County**	**State**	**Department**	**% of Practice**

TEACHING/MEDICAL DIRECTORSHIPS

Do you have any teaching and/or medical director responsibilities for any insurance or health care related organization?	☐ Yes ☐ No
Do you hold any positions outside of your principal medical or surgical practice (e.g., moonlighting in an E.R. or part-time at a clinic or nursing home)?	☐ Yes ☐ No
If you answered YES to either question above, please complete the following:	
Name of Facility:	
County/State:	
Title/Position:	
Do you receive medical malpractice coverage from the any of the above entities for either:	
a. Administrative activities?	☐ Yes ☐ No
b. Direct patient care?	☐ Yes ☐ No
What percentage of your time is devoted to teaching?	%

PRACTICE INFORMATION

Are you entering practice for the first time since completing an internship, residency or fellowship program?	☐ Yes ☐ No
Have you practiced continuously for the past ten (10) years? **If NO, please explain in the Supplemental Information Worksheet.**	☐ Yes ☐ No
Has your specialty, procedures, location(s), etc., changed in the past ten years? **If YES, please explain noting dates of changes in the Supplemental Information Worksheet**	☐ Yes ☐ No
Do you perform any work, either full-time or part-time, for any state government or the federal government? **If YES, please explain in the Supplemental Information Worksheet**	☐ Yes ☐ No
Are you on active duty in the U.S. Military Service?	☐ Yes ☐ No
Please indicate the average number of hours you work per week (include office hours, administrative activities for your practice as well as any hospitals, procedures, direct patient care, consultations, etc.)	
☐ **10 hours or less per week** ☐ **11 to 20 hours per week** ☐ **21 to 30 hours per week** ☐ **31 hours or more per week**	
Please indicate the practice hours to be insured by AMS RRG:	
If part-time, when did you begin practicing on a part-time basis?	
Estimate the number of patients you see on an average day of clinical practice:	

INSURANCE HISTORY

Please detail your insurance carriers for the previous fifteen years. Please explain any gaps in your coverage on the Supplemental Information Worksheet.					
Dates Mo/Yr		Insurance Carrier	Policy #	Type of Policy	Retroactive Date
From	To				
/	/				
/	/				
/	/				

Have you ever practiced without insurance or allowed a clams-made policy to lapse without the purchase of tail or nose coverage?	☐ Yes ☐ No
Have you ever had professional liability insurance refused, declined, non-renewed, cancelled, or accepted on special terms?	☐ Yes ☐ No
Have you ever been required to pay a premium surcharge or have you ever been involved in an appeal concerning the imposition of such a surcharge?	☐ Yes ☐ No

NOTE: If you answer YES to any question in the section above, provide detailed description on the Supplemental Information Worksheet

PRACTICE/CORPORATE STRUCTURE

Indicate all practice situations that apply to you:			
☐	"Solo" Physician (unincorporated)	☐	Locum Tenens
☐	"Solo" Professional Corporation (PC)	☐	I employ other physicians (If not insured with AMS RRG, please submit proof of current coverage)
☐	Stockholder of a PC with more than 1 physician		
☐	Employed by another physician/corporation already insured by AMS RRG	☐	Employed by another physician/corporation insured by a different Medical Malpractice Insurer

If applicable, please complete section below:			
Entity Name	Retroactive Date	Date of Incorporation	Corporate Tax Identification Number

Do you have office or expense sharing arrangements with any other physician(s) or practice group(s) not disclosed?	☐ Yes ☐ No
Do you wish corporation coverage for any of the above listed entities? If YES, do you wish to share your individual limits with this business entity, or do you desire separate limits of liability for the business entity?	☐ Yes ☐ No ☐ Shared ☐ Separate

If you are requesting separate corporate limits, please check which limit per claim/annual aggregate	
☐ $100,000 /$300,000	☐ $500,000/$1,500,000 (PA Only – Enrolled in PCF)
☐ $200,000/$600,000	☐ $1,300,000/$3,900,000 (NY Only)
☐ $250,000/$750,000	☐ $2,300,000/$6,900,000 (NY Only)
☐ $500,000/$1,500,000	☐ $$2,500,000/$7,500,000 (VA Only - Per statutory maximum Code of VA Sec 8.01-581.15)
☐ $1,000,000/$3,000,000	☐ $2,000,000/$6,000,000

NOTE: Corporate limits of liability requested may not exceed physician limits of liability

List all physicians/physician extenders practicing in the Professional Entities noted above (this should include current or former physicians/physician extenders for whose acts the entity is legally responsible).			
Physician/Physician Extender Name	**Insured with AMS RRG**	**Vicarious coverage requested**	**Employment Start and Stop Date**
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
Please indicate the total number of physicians/physician Extenders listed here and on the Supplemental Information Worksheet			

ADDITIONAL HEALTHCARE PROVIDERS – PHYSICIAN EXTENDERS

Physician Extender Classification	Number Employed/ Contracted	Coverage Needed	Physician Extender Classification	Number Employed/ Contracted	Coverage Needed
Certified Nurse Midwife		☐ Yes ☐ No	Physician Assistant		☐ Yes ☐ No
Certified Nurse Practitioner		☐ Yes ☐ No	Physical Therapist		☐ Yes ☐ No
Certified Registered Nurse Anesthetist		☐ Yes ☐ No	Psychologist		☐ Yes ☐ No
Chiropractor		☐ Yes ☐ No	Surgeon Assistant		☐ Yes ☐ No
Optometrist		☐ Yes ☐ No	O.R. Technician		☐ Yes ☐ No

NOTE: If you indicated any Physician Extenders above, then the following section must be completed. Use the Supplemental Information Worksheet if more space is needed.

Physician Extender Name	Classification	Hours Worked Per Week	Limits Shared (S) Separate (P) Other Insurer (O)
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
		☐ FT ☐ 21 to 30 ☐ 11 to 20 ☐ 0 to 10	☐ S ☐ P ☐ O
If you supervise Certified Nurse Practitioners, Nurse Midwives, or Physicians Assistants, what is the average Paramedical Employee/Physician Ratio?			_______%
Do any of the Physician Extender employees (excluding physicians) practice at a location geographically separate from yours? If YES, describe in the Supplemental Information Worksheet.			☐ Yes ☐ No

SPECIALTY CLASSIFICATION SECTION

Please indicate the percentage of your time devoted to the following specialties (must total 100%). As an example, a Family Practitioner who has an Obstetrics practice should indicate the percentage of each:					
	Administration Medicine		Hand Surgery		Pathology
	Allergy		Hematology		Pediatric Medicine–**under age 17**
	Anesthesiology-Inpatient		Hospitalist		Pediatric Surgery
	Anesthesiology-Outpatient		Infectious Disease		Physiatrist/Rehab Medicine
	Bariatric Surgery		Integrative Medicine		Plastic Surgery
	Cardiology		Intensive Care Medicine		Podiatry
	Cardiology w/Angioplasty		Internal Medicine		Preventive Medicine
	Cardiology w/Catheterization		Neonatology		Psychiatry
	Colon & Rectal Surgery		Nephrology		Public Health
	Dermatology		Neurology		Pulmonary Medicine
	Emergency Medicine		Neurosurgery		Radiation Therapy
	Endocrinology		Obstetrics & Gynecology		Radiology – Diagnostic
	Family Practice		Occupational Medicine		Radiology – Mammography
	Fertility Medicine		Oncology		Radiology Neuro-intervention
	Gastroenterology		Oncology – Minor Surgery		Rheumatology
	General Medicine		Orthopedic Sx – no Spine		Thoracic Surgery
	General Surgery		Orthopedic Sx – with Spine		Trauma Surgery
	Geriatrics		Otolaryngology – Major Sx		Urgent Care
	Gynecology – No Surgery		Otolaryngology – Minor Sx.		Urology
	Gynecology-Major Surgery		Otolaryngology w/Cosmetic		Vascular Surgery
	Gynecology-Minor Surgery		Pain Management-incl implants		Other – Please Describe →

NOTE: Please note that physicians should indicate above the percentage of time they spend treating children under the age of 17 (Pediatrics) and the time they spend treating neonates (Neonatology) by filling in the appropriate box above.

Please indicate the percentage of your practice devoted to the following activities (must total 100%):					
	Emergency Room/Urgent Care		Hospital Surgery / Surgicenter		Nursing Home Patients
	*Integrative Medicine		In office Surgery		In Office Patient Visits / Office Rounds
	Home visits		Moonlighting		*Telemedicine / Telehealth

NOTE: If you are providing Integrative Medicine and/or Telemedicine/Telehealth services, you will be required to complete an AMSRRG Supplemental Questionnaire.

Please indicate which one of the following best describes your practice:	
☐	No Surgery – Includes incision of boils and superficial abscesses, or suturing of skin or superficial fascia
☐	Minor Surgery – Any operation that involves a surgical incision into the dermis, epidermis and superficial fascia or suturing of skin or superficial fascia and does not enter below the superficial fascia or any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis.
☐	Major Surgery – Includes any operation done under general anesthesia, or any operation that presents a distinct hazard to life such as removal of tumors, reduction of open fractures, amputations, abortions, tonsillectomies, adenoidectomies, cesarean sections, dilation and curettage, vasectomies, the removal of any gland or organ, plastic surgery. **This includes assisting in surgery.**

Cosmetic Procedures – Please Check All That Apply					
☐	Abdominoplasty	☐	Blepharoplasty	☐	Coronal Lift
☐	Hair Implants	☐	Penile Cosmetic Surgery	☐	Sex Reassignment Surgery
☐	Autologous Fat Injection	☐	Breast Augmentation	☐	Breast Reduction
☐	Endoscopic Forehead Lift	☐	Implants other than Breast	☐	Rhinoplasty (cosmetic)
☐	Thread Lift	☐	Breast Reduction	☐	Facial Laser Resurfacing
☐	"Lifestyle" Lift	☐	Rhytidectomy	☐	Other (Describe below)
☐	Large Volume Liposuction (over 5,000 cc) in a Hospital				
☐	Large Volume Liposuction (over 5,000 cc) in a Freestanding Surgery Center or Surgical Suite				

NOTE: Provide further details for any procedures indicated above on the Supplemental Information Worksheet

Please indicate if you or any of your staff perform the following procedures:			
Procedure	**Physician**	**Non-Physician Licensed Staff**	**Non-Licensed Staff**
Botox Injections	☐	☐	☐
Chemical Peel	☐	☐	☐
Collagen Injections	☐	☐	☐
Cosmetic Tattooing	☐	☐	☐
Laser Hair Removal	☐	☐	☐
Laser Wrinkle Removal	☐	☐	☐
Micro-Dermabrasion	☐	☐	☐
Permanent Make-up	☐	☐	☐
Sclerotherapy	☐	☐	☐
Other _____	☐	☐	☐

Please answer the following questions:	
Are you credentialed to provide Conscious sedation?	☐ **Yes** ☐ **No**
Moderate Sedation	☐ **Yes** ☐ **No**
Deep Sedation	☐ **Yes** ☐ **No**
Are you certified in ACLS?	☐ **Yes** ☐ **No**
Are you certified in ATLS?	☐ **Yes** ☐ **No**
Are you certified in PALS?	☐ **Yes** ☐ **No**
Do you perform any procedures, techniques, or treatment modalities that are not typical of your specialty or that required separate hospital credentialing?	☐ **Yes** ☐ **No**
Do you solicit or advertise to weight control patients?	☐ **Yes** ☐ **No**
Do you prescribe medications for weight loss?	☐ **Yes** ☐ **No**
Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy?	☐ **Yes** ☐ **No**
Do you perform any of the following procedures?	
Bioidentical Hormone Therapy	☐ **Yes** ☐ **No**
Chelation Therapy	☐ **Yes** ☐ **No**
High Pressure Hyperbaric Oxygen Therapy	☐ **Yes** ☐ **No**
Oxidative Therapy/Ozone Therapy	☐ **Yes** ☐ **No**
Prolotherapy or Platelet Rich Plasma Injections	☐ **Yes** ☐ **No**
Stem Cell Therapy	☐ **Yes** ☐ **No**
Neural Therapy	☐ **Yes** ☐ **No**

NOTE: If you answer YES to any question in the section above, provide detailed description on the Supplemental Information Worksheet

SPECIFIC SPECIALTY CLASSIFICATION SECTION

CARDIOLOGY – Please indicate which of the following you perform	
Non-invasive Cardiology – includes echocardiography, stress testing, TEE	☐
Nuclear Medicine	☐
Cardiac Catheterization: Non-interventional	☐
Cardiac Catheterization: Interventional – including angioplasty, stent placement etc.	☐
Electrophysiology – including placement of AICD	☐

GENERAL SURGERY – Please indicate which of the following you perform	
Gastric Bypass Surgery – If yes, please enter the approximate number per year	☐
Gastric Banding Procedures – If yes, please enter the approximate number per year	☐
Vascular Surgery – Standard procedures	☐
Vascular Surgery – Including Carotid Artery Stents	☐

OBSTETRICS/GYNECOLOGY AND ENDOCRINOLOGY – Please indicate which of the following you perform	
Number of deliveries per year – vaginal	
Number of deliveries per year – C-section	
Percentage of deliveries with Neonatologist present	
Number of termination of pregnancies performed per year	
Number of Vitro Fertilization procedures per year	

OPHTHALMOLOGY – Please indicate which of the following you perform	
Medical Procedures Only	☐
Minor Surgical Procedures including:	
Assisting in Surgery, Laser Iridotomy, Laser Ablation of Corneal Lesion	
Suture Tarsorrhaphy, Thermage, Laser Capsulotomy, Laser Iridoplasty	☐
Wedge resection of noncancerous lesion	
Laser Capsulotomy or Iridoplasty	
Lasik – Indicate # of Procedure/month	/mo
Major Surgery/All procedures	☐

ORTHOPEDIC SURGERY – Please indicate which of the following you perform	
No spinal surgery	☐
Limited Spinal Surgery – Lumbar Spine only	☐
Full Spinal Surgery including the C-Spine	☐

OTOLARYNGOLOGY – Please indicate which of the following you perform	
Office procedures only	☐
Acoustic tumor surgery	☐
Radical Neck Surgery – if yes, please indicate approximate number per year - _____	☐

PATHOLOGY – Please indicate which of the following you need coverage for	
Interpretation of Pap Examinations	☐
I will sign final reports for my colleagues without reviewing the slides	☐ **Yes** ☐ **No**

PRIMARY CARE – Please indicate which of the following you perform	
Treatment of children under the age of 17	☐
Treatment of infants and/or neonates	☐
Assist in Surgery performed in an operating room or Surgery Center – use Supplemental Information Worksheet to describe	☐
Perform Surgery in an operating room or Surgery Center – use Supplemental Information Worksheet to describe	☐
I interpret the x-rays performed in my office, without a Radiologist over read	☐
Sigmoidoscopy – other than Gastroenterologists or General Surgeons	☐
Colonoscopy – other than Gastroenterologists or General Surgeons	☐

CONCIERGE MEDICINE – Please answer the applicable questions below	
Do you have a concierge medicine practice? – If yes, please answer the following questions.	☐ **Yes** ☐ **No**
How many years have you had a concierge medicine practice?	**Yrs**
What percentage of your practice does this represent?	**%**
How many patients do you have at present and how many will you accept at a maximum?	**/**

UNDERWRITING & ELIGIBILITY SECTION

Please answer the following questions. Have you **EVER**:	
Had or become aware of any chronic illness or physical defect that impairs or could possibly impair your ability to practice any aspect of medicine?	☐ **Yes** ☐ **No**
Been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, non-renew or revoke your clinical privileges?	☐ **Yes** ☐ **No**
Been treated, evaluated, or hospitalized for any of the following disorders? (Please check all that apply) ☐ Alcohol ☐ Narcotics ☐ Central nervous systems stimulants or depressants ☐ Mental or emotional disorders	☐ **Yes** ☐ **No**
Been indicted and/or convicted of a crime other than minor traffic violations?	☐ **Yes** ☐ **No**
Been under investigation by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended or limited in any way?	☐ **Yes** ☐ **No**
Had Medicare/Medicaid fraud charges filed against you?	☐ **Yes** ☐ **No**
Been suspended, restricted, or put on probation by any governmental health program (e.g. Medicare or Medicaid)?	☐ **Yes** ☐ **No**

NOTE: If you answered YES to any of the above questions, please provide full details on the Supplemental Information Worksheet. In addition, if you answered any question related to your personal health with a YES, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

KNOWN CLAIMS AND MEDICAL INCIDENTS

Have you **EVER** been involved in a malpractice claim or suit with an incident date, report date or close date occurring within the last fifteen (15) years or are you presently involved in malpractice litigation? **Include a separate incident/claim information worksheet for each of these events.**	☐ Yes ☐ No

Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?		**INITIAL BELOW**
A. A request for records from a patient and/or attorney related to an adverse outcome?	☐ Yes ☐ No	
B. A letter from a patient and/or attorney regarding your medical treatment of a patient?	☐ Yes ☐ No	
C. Intra-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	☐ Yes ☐ No	
D. Has your hospital filed any governmental reports regarding a complication related to your treatment of a patient?	☐ Yes ☐ No	
Are you aware of a patient's dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you?	☐ Yes ☐ No	
Have all circumstances that might reasonably lead to an incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐ Yes ☐ No ☐ None to Report	
→ If you answered YES to any of the above questions, please provide all of the specifics for each case on a separate Prior Claims Information Worksheet.		

I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier.

_____ ____/____/_____

SIGNATURE **DATE (MM/DD/YY)**

NOTE: Included with your application materials is a separate No Known Loss Letter. If you have not received one, please contact AMS RRG.

PRIOR CLAIMS INFORMATION WORKSHEET

Please copy this page as necessary to summarize all medical malpractice claims that you have experienced in your complete practice history. This includes all patients requesting payment to avoid a lawsuit, all notices of intent to sue that did not lead to a lawsuit and information on all lawsuits filed whether or not a payment was made.

Name of Patient:							
Name of Insurance Carrier:							
Nature of the Claim: (check all that apply)	☐	**Incident**	☐	**Claim Letter**	☐	**Notice of Intent to Sue**	
	☐	**Lawsuit**	☐	**State Board Investigation**			
Date of Medical Incident:	/ /			**Date Reported to your insurer**		/ /	
Current Status:	☐	**Open**	☐	**Closed → note date**		/ /	
For Closed Claims							
Amount Paid on your Behalf:	$			**Amount Paid for all Defendants**		$	
For Open Claims							
Expense Reserves	$			**Indemnity Reserves**		$	

Please provide a detailed account of the events surrounding this claim. This will help us better understand the nature of the claim. In addition, this information will be used to help our physicians reduce their risk of future claims. Please use the Supplemental Information Worksheet as necessary. Again, please be detailed in your description.

Note: You may be requested to provide additional information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.

SUPPLEMENTAL INFORMATION WORKSHEET

Please use this page to provide all additional information that you feel is necessary to accurately complete the application. Please label each answer with the question that it applies to within this application.

Question # **Answer**

ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer, _____, both the right to cancel my policy and the return of any unearned premium due to policy changes (e.g. termination of coverage, limit decrease, etc.) for which my employer has paid the premium. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

→ **Initial Here** [ ]

AUTHORIZATION TO RELEASE SHARES OF STOCK

I hereby authorize the release of all shares of stock to my employer, _____, for which my employer has paid the capital contribution. (Professional Entity/Payor must also be approved for and accept coverage through AMS RRG).

→ **Initial Here** [ ]

PHYSICIAN CERTIFICATION

Incomplete or incorrect information could result in a retroactive upward premium adjustment or could lead to a denial of liability in the event of a claim. I also understand that any material misrepresentation or omission made by me on this application may render any contract of insurance null and without effect or provide the company with the right to rescind it.

I hereby declare that the statements and responses I have provided in this application are complete and true and that I have not knowingly suppressed or misstated any material facts. I agree to immediately notify the company in writing if there is any future material change in any answer to this application, including without limitation, any change in my professional status, specialty, affiliation, or working arrangement with any other physician, firm, or professional association, and I understand and agree that such changes are material to the risks covered by the policy of insurance I am applying for.

By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued. I understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) offered me a premium quote, and (3) received, as a precondition to coverage, the total premium due or, if the company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

I agree that if I fail to comply with these terms, I will have no coverage for any claim under any policy of insurance for which I am applying.

PRIVACY AGREEMENT

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as modified by the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and related rules and as may be modified subsequently (the "Privacy Regulations"). Under the Privacy Regulations, you are a "covered entity," and as required by 45 C.F.R. Section 164.502(e) and 45 C.F.R. Section 164.504(e), we acknowledge that we, in certain instances, may be your "business associate." We must use and disclose information that identifies an individual; relates to health, health treatment, or healthcare payment; and is maintained in any form (e.g., electronic, paper, oral) ("Protected Health Information" or "PHI") in our performance of services under this Policy, and we agree to abide by the assurances, terms, and conditions contained herein in the performance of our obligations.

We agree as follows:

A. Permitted Uses and Disclosures of Protected Health Information.

Pursuant to this Agreement, we provide services ("Services") for your operations that may involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, quality assessment; quality improvement; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of healthcare practitioners and providers; credentialing, conducting, or arranging for medical review; arranging for legal services; conducting or arranging for

audits to improve compliance; resolution of internal grievances; placing stop-loss and excess of loss insurance; and other functions necessary to perform these Services. Except as otherwise specified herein, we may make any uses

of Protected Health Information necessary to perform our obligations under this Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, we may disclose Protected Health Information for the purposes authorized by this Agreement:

(i) to our employees, subcontractors, and agents, in accordance with Section D(5) below; (ii) as directed by you in writing; or (iii) as otherwise permitted by the terms of this Agreement. Additionally, unless otherwise limited herein, we are permitted to make the following uses and disclosures:

B. Our Obligations and Activities.

We may use and disclose the Protected Health Information in our possession to third parties for the purpose of our proper management and administration, such as obtaining reinsurance, or to fulfill any of our present or future legal responsibilities, such as complying with insurance regulator requests, provided that (i) the disclosures are required by law; or (ii) we have received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 C.F.R. Section 164.504(e)(4) and where necessary received a BAA.

C. In addition to using the Protected Health Information to perform the services set forth above, we may:

(1) Aggregate the Protected Health Information in our possession with the Protected Health Information of other covered entities that we have in our possession through our capacity as a business associate to said other covered entities, provided that the purpose of such aggregation is to provide you with data analyses relating to your healthcare operations. Under no circumstances may we disclose Protected Health Information of one covered entity as defined by 45 C.F.R. Parts 160 and 164 to another covered entity absent your express written authorization; and

(2) De-identify any and all Protected Health Information provided that the de-identification conforms to the requirements of 45

C.F.R. Section 164.514(b), and further provided that you are sent the documentation required by 45 C.F.R. Section 164.15(b), which shall be in the form of a written assurance from us. Pursuant to 45 C.F.R. 164.502(d)(2), de-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement.

GENERAL FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

ALABAMA FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO FRAUD WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA FRAUD 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.

FLORIDA FRAUD NOTICE WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

IDAHO FRAUD WARNING: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, 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.

KENTUCKY FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

LOUISIANA FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE FRAUD WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MARYLAND FRAUD WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA FRAUD WARNING: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW JERSEY FRAUD WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK FRAUD WARNING: 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.

OHIO FRAUD WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON FRAUD WARNING: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA FRAUD WARNING: 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 subjects such person to criminal and civil penalties.

RHODE ISLAND FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE FRAUD WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance

company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

TEXAS FRAUD WARNING: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

VIRGINIA FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON FRAUD WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or another person, files 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, subject to criminal prosecution and civil penalties.

By your signature, you indicate to all the rules and regulations set by Applied Medico-Legal Solutions Risk Retention Group, Inc.

Print Applicant Name:	
Applicant Signature:	
Date:	/ /

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance with Applied Medico-Legal Solutions Risk Retention Group, Inc. (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney or the Company may have a bearing upon the undersigned's acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for any state in which he has practiced, or resided, and any and all physicians or any other third party having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon the undersigned's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or entities releasing the information described above, their agents, servants and employees, and the Company and any of its present or former directors, officers, employees, agents and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

The undersigned hereby acknowledges that the persons and entities releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or entities releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and entities described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Print Applicant Name:	
Applicant Signature:	
Date:	/ /

Please remit your completed application to:

Applied Medico-Legal Solutions Risk Retention Group, Inc.
c/o AMS Management Group
23 Route 31 North, Suite A-20
Pennington, New Jersey 08534

Phone: 609-737-1154
Toll-free 866-461-1221
Fax: 609-737-1186