APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

CLAIMS-MADE PROFESSIONAL LIABILITY RENEWAL APPLICATION

For Physicians & Surgeons

GENERAL INFORMATION

Policy Number	Renewal Date	Broker
Policyholder's Full Name	**Date of Birth**	**Practice Website**

Principal Office Practice Address

Mailing/Billing Office Address

Office Phone	Office Fax	Physician E-Mail Address
Practice Administrator Name		**Practice Administrator E-Mail Address**

I would like to receive risk management information from AMS Management Group:	☐ **Yes** ☐ **No**

PRACTICE AND UNDERWRITING INFORMATION

(Please explain all "Yes" answers in the "Supplemental Section" of the Renewal Application)

Has your practice location(s) and/or contact information changed since your last application to us?	☐ **Yes** ☐ **No**
Have you formed a new corporation? If yes, please provide name of corporation and date formed.	☐ **Yes** ☐ **No**
Do you desire coverage for any existing or new professional corporations? If yes, please provide formal name of corporation.	☐ **Yes** ☐ **No**
Are you Board Certified? If yes, indicate specialty and date.	☐ **Yes** ☐ **No**
Do you provide services at a nursing home, skilled nursing facility or assisted living center? If yes, indicate the % of your practice devoted to these services.	☐ **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:	
Please indicate if you have completed 4 hours of risk management CMEs through Adaptrack or Law & Medicine during the preceding policy year, which may be considered in the renewal pricing of your account: **CME's Completed Through:** ☐ **Adaptrack** ☐ **Law & Medicine** (You may access the discounted courses in the "For Members" section via *www.AMSRRG.com*)	☐ **Yes** ☐ **No**
Do you provide any Telemedicine Services? If 'yes' you will be required to complete an AMSRRG Telemedicine Questionnaire	☐ **Yes** ☐ **No**

SPECIALTY CLASSIFICATION SECTION

Has your specialty or procedures performed changed since your last application to us? **Please indicate your specialty here:**	☐ **Yes** ☐ **No**
Do you solicit or advertise to weight control patients?	☐ **Yes** ☐ **No**
Do you prescribe medications for weight loss? (If yes, indicate the medications in the Supplemental Section.)	☐ **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? If yes, please describe.	☐ **Yes** ☐ **No**
Please indicate if you are performing 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**
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 require separate hospital credentialing? If yes, please describe these procedures.	☐ **Yes** ☐ **No**

Cosmetic Procedures – Please Check All That Apply

☐	Abdominoplasty	☐	Blepharoplasty	☐	Coronal Lift
☐	Hair Implants	☐	Penile Cosmetic Surgery	☐	Sex Reassignment Surgery
☐	Autologous Fat Injection	☐	Breast Augmentation	☐	Rhinoplasty (cosmetic)
☐	Endoscopic Forehead Lift	☐	Implants other than Breast	☐	Facial Laser Resurfacing
☐	Thread Lift	☐	Breast Reduction	☐	Fat Injections into the Buttocks:
☐	"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				

Please use the Supplemental Information Worksheet to provide any further details regarding these procedures.

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 _____	☐	☐	☐

ADDITIONAL HEALTHCARE PROVIDERS – PHYSICIAN EXTENDERS

Please indicate if you employ or contract any of the following 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

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

If you supervise Certified Nurse Practitioners, Nurse Midwives, or Physicians Assistants, what is the average Paramedical Employee/Physician Ratio?	_______%
Do any of the Paramedical Employees practice at a location geographically separate from yours? If YES, describe in the Supplemental Information Worksheet.	☐ Yes ☐ No

PRACTICE AND UNDERWRITING INFORMATION

In order to determine eligibility and qualify for a loss free discount on the renewal of your medical malpractice insurance through AMS RRG, Inc., please submit a recently valued loss run (dated within the most recent 60 days) from all previous insurance carriers and return with this completed renewal application

Please answer the following questions. Have you EVER: **(Explain all "Yes" answers in the "Supplemental Section" of the Renewal Application)**	
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
Since your last application to us, have there been any judgments, settlements, or dismissals of any previously reported claims, regardless of insurance carrier?	☐ Yes ☐ No

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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.

Section & Page Number	Answer

PHYSICIAN OR AUTHORIZED REPRESENTATIVE CERTIFICATION

I hereby declare that the above statements and particulars are 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.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the company with the right to rescind it. 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 further 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.

I also understand that the company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the company any information regarding me, which the company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

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:	
Insured Signature or Authorized Representative:	
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