Roush Insurance Services, Inc.

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- ☐ **Deerfield Insurance Company**
- ☐ **Evanston Insurance Company**
- ☐ **Essex Insurance Company**
- ☐ **Markel American Insurance Company**
- ☐ **Markel Insurance Company**
- ☐ **Associated International Insurance Company**

RENEWAL APPLICATION FOR PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY INSURANCE

Notice: The policy for which application is made applies only to "Claims" first made during the Policy Period. The limits of liability shall be reduced by "Claim Expenses" and "Claim Expenses" shall be applied against the deductible, unless the policy is amended by endorsement. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

1. (a) (i) Full name of Renewal Applicant: _____

   (ii) Expiring Policy No.: _____ Expiration Date: _____

   (b) Principal practice address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (d) (i) E-Mail Address: _____ (ii) Website Address: _____

2. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)*
   [ ] professional corporation* [ ] professional association*
   [ ] limited liability company* [ ] partnership*
   [ ] employee of _____ [ ] independent contractor of _____
   [ ] other _____
   * Specify name of entity: _____

   (b) Do you want coverage for the entity named Item 2(a) above? ..... [ ] Yes [ ] No

3. Provide your medical or surgical specialty: _____

4. Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .....[ ] Yes [ ] No
   Our Business Associate Agreement is available at https://www.markelcorp.com/en/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

5. Since the application for the policy identified in Question 1.(ii) above:
   (a) Have you been notified to respond to, appear before or have you been investigated or are you currently being investigated by any State Board of Medical Examiner's Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? .....[ ] Yes [ ] No
   (b) Has your license to practice medicine or your permit to practice or prescribe or dispense drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?.....[ ] Yes [ ] No
   (c) Have been asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? .....[ ] Yes [ ] No
   (d) Have your privileges at any hospital or other institution been reduced, denied, revoked, restricted or suspended? .....[ ] Yes [ ] No
   (e) Have you been charged with or convicted of any act committed in violation of any law or ordinance? .....[ ] Yes [ ] No
   (f) Have you been diagnosed with or treated for any medical or mental condition or impairment that might affect your ability to practice medicine? .....[ ] Yes [ ] No

   If Yes to any question above, provide details. _____

   _____

6. (a) Are you American Board certified? .....[ ] Yes [ ] No
   (i) If Yes, provide the medical specialty in which you are certified: _____

(b) Since the application for the policy identified in Question 1.(ii) hereinabove have there been any changes in your Board Certification status, medical specialty, practice or procedures performed? [ ] Yes [ ] No
(i) If Yes, provide details. _____

7. (a) Average weekly patient load: _____ (b) Average number of hours you practice each week: _____

8. Do you anticipate any changes in your practice in the next year? ..... [ ] Yes [ ] No
If Yes, attach a detailed explanation.

9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location, skilled nursing facility or assisted living center? ..... [ ] Yes [ ] No
If Yes, provide what percentage of your practice? _____%

10. Do you perform deliveries? ..... [ ] Yes [ ] No
If Yes, provide the estimated number of deliveries you will perform in the next 12 months:
(a) Vaginal births: _____
(b) Vaginal births after Cesarean Section: _____
(c) Cesarean Sections: _____

11. Since the application for the policy identified in Question 1.(ii) above have you added any professional associates or employees, independent contractors, partners, nurse practitioners, physician's assistants, CRNAs? ..... [ ] Yes [ ] No
If Yes, attach provide a list including the names of each practitioner and submit a separate application for each practitioner to be covered under this policy or confirmation of current Medical Malpractice Insurance.

12. Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin and superficial fascia? ..... [ ] Yes [ ] No
If Yes, provide an estimated number of surgeries that you will perform in the next 12 months. _____

13. Since the application for the policy identified in Question 1.(ii) above have you changed hospitals and/or surgi-centers where you are currently on staff? ..... [ ] Yes [ ] No

14. Since the application for the policy identified in Question 1.(ii) above:
(a) Have there been any judgments, settlements, or dismissals of any previously reported claims to the Company or any prior insurer? ..... [ ] Yes [ ] No
(b) Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? ..... [ ] Yes [ ] No
If Yes, complete a copy of our Supplemental Claim form for each one.
(c) Has any claim or suit for malpractice been made against you or any entity proposed for this insurance? ..... [ ] Yes [ ] No
If Yes, complete a copy of our Supplemental Claim form for each one.

15. Do you currently participate in or plan to participate in:
(a) a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? ..... [ ] Yes [ ] No
(b) the Virginia Birth-Related Neurological Injury Compensation Program? ..... [ ] Yes [ ] No

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

This renewal application and any materials submitted herewith are supplemental to all application(s) and renewal application(s) and any materials submitted therewith for all policies of which this policy would be a renewal. All such application(s) and renewal application(s) and any materials submitted therewith, together with this renewal application and any materials submitted herewith, shall be deemed attached hereto as if physically attached hereto, and shall constitute the complete renewal application. The renewal application shall be the basis of the contract should a renewal policy be issued and will be attached to and become a part of the renewal policy. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and attachments in issuing any policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

(i) the policy for which this application is made applies only to "Claims" first made during the "Policy Period";

(ii) unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by "Claim Expenses" and, in such event, the Company will not be liable for "Claim Expenses" or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy; and

(iii) unless amended by endorsement, "Claim Expenses" shall be applied against the "Deductible".

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant	Title
Signature of Applicant	Date

Notice to Applicants: 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 the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS