SIMED

Application for Claims Made Physicians, Surgeons and Podiatrist Professional Liability Insurance Policy

This Application must be typed or completed in ink and signed and dated by the applicant. The information provided by you must be legible. Coverage is available to all qualified applicants as they are defined in the Article 41.020 of Chapter 41 of the Insurance Code of Puerto Rico.

Please answer every question fully and include any supporting or requested documents, and any additional information you feel may be of assistance to the Underwriter such as Brochures, office letterhead, etc. Should there be insufficient spaces in the application form for full details, please attach further information on signed and dated sheets, wherever possible following the same format and question number.

If your application is approved by the Syndicate the coverage can be provided with an inception or commencement date no earlier than the day SIMED receive the payment of the quoted premium. Under the claims made policy form, coverage is only provided for claims against the Insured arising out of medical incidents that occur on or after the Retroactive Date stated in the policy and which are reported in writing to the Syndicate while the policy is in effect, unless additional reporting period coverage is purchased which would provide an unlimited time period to report covered claims. During the first three policy years claims made premium are lower and they increase gradually, independent of overall rate increase, until the claims made risk reach maturity at fourth year. The premium may also be affected due to your past loss/claims experience information.

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PO Box 8969
San Juan, PR 00910

Application for Claims Made Physicians, Surgeons and Podiatrist Professional Liability Insurance Policy

I. Personal Information

1. Name of Applicant: _____
   (First) (Middle) (Father Last Name) (Mother Maid Name)
2. Gender : ☐ Male ☐ Female
3. Mailing Address: _____
   _____
4. Work or Professional Office Address: _____
   No. Street
   _____
   City State Zip Code
5. Home Address: _____
   No. Street
   _____
   City State Zip Code
6. Office Telephone Number: _____ Fax Number: _____
   Work Telephone Number: _____
   Home Telephone Number: _____ E-Mail Address: _____
   Mobile Phone Number: _____ Website Address: _____
7. Date of Birth: _____ _____ _____ Place of Birth: _____
   Mo. Day Yr.
8. Social Security No: _____
9. Are you duly registered and licensed to practice your profession in the Commonwealth of Puerto Rico? ☐ Yes ☐ No
   Provide a certification issued to SIMED by the corresponding Licensing Board indicating that your license is in force and have never been suspended or revoked. Attach a copy of your medical license, medical license, your registration card and, in the case of physicians and surgeons, a certification issued by the Puerto Rico College of Physicians indicating that you have paid the annual fee required by law.
   License No: _____ ☐ Physician or surgeons ☐ Podiatrist: _____
   Register No: _____ Date Issued: _____ Expiration Date: _____
10. Please indicate your Federal DEA License No: _____ (PR) _____

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II. Applicant Education

1. Complete the following information:

	Area of Specialization	Hospital/College	City & State	From (Date)	To (Date)	Graduation Date
School of Medicine						
Internship						
Residency Specialty (if any)						
Additional Residency Sub-specialty						
Fellowship						

2. **Are you** Board Certified by the American Board of Medical Surgical Specialties?

☐ Yes ☐ No

If answer yes, is please indicate the specialty(ies) for which you are Board Certified and attach copy of your current certification(s)_____, _____, _____

_____, _____
Dated Issued Valid Through

III. Practice/Rating Information

1. Please specify the type of coverage you are applying for:
   a. **Primary Policy Limits**
      ☐ $100,000 per medical incident/$300,000 aggregate
   b. **Excess over primary policy limits**
      ☐ $150,000 per medical incident/$300,000 aggregate
      ☐ $400,000 per medical incident/$800,000 aggregate
      ☐ $650,000 per medical incident/$1,300,000 aggregate
      ☐ $900,000 per medical incident/$2,700,000 aggregate
2. Please indicate if your current practice is as a ☐ general practitioner or ☐ specialist or ☐ podiatrist **(Specify bellow all the specialties, indicating the percent of your time spent to such practice.)**
   Specialty:_____ % of Practice_____
   Other Specialties (Subspecialty if any): _____ % of Practice_____
3. Do you will be practicing on a limited basis? ☐ Yes ☐ No
   If yes, please explain and indicate the following:
   No. of working days per week _____ No. of Practicing hours per day _____
   No. of patients per week _____
4. What is the nature of your current practice?
   ☐ Solo Practitioner
   ☐ Solo or Single Professional Corporation (PC) **(If yes, please complete the attached Exhibit 1 and Exhibit 2)**

☐ Multi Professional Corporation (PC) **(If yes, please complete the attached Exhibit 1 and Exhibit 2)**
☐ Independent Contractor
☐ Professional Association (P.A.) **(Provide details on the attached sheet for this purpose)**
☐ Professional Partnership **(If yes, please complete the attached Exhibit 1 and Exhibit 2)**
☐ Other **(Describe or provide details on the attached sheet for this purpose)**

5. Do you or does your partnership or corporation or association have employees? ☐ Yes ☐ No
(**If yes, please complete the attached Exhibit 2.)**

6. Do you render urgency or emergency room services?

☐ Yes ☐ No

If the answer to this question is "yes", answer the following

(a) As a requirement for staff privileges ☐ Yes ☐ No
If yes, please indicate if the institution (hospital/clinic) extend or provide professional liability insurance coverage to you regarding these services.

_____
Name of Hospital/Clinic

(b) On a fee or contract basis ☐ Yes ☐ No
(c) On a salary basis ☐ Yes ☐ No

If the answer to (b) and (c) above is yes, please provide the name of your contractor and the name of each institution for which you work; and, for each one, indicate below the number of daily, weekly and monthly hours dedicated to such work.
(**Attach to this application a certification of your work schedule at each institution.)**

Name of Contractor	Emergency or Urgency Schedule			
Institution Name	Institution Name	Number of Hours Worked		
		Daily	Per Week	Per Month

7. Do you work in an intensive care hospital unit? ☐ Yes ☐ No
(If yes, answer please complete the Exhibit 3 attached to this application.)

8. If you are a pathologist, do you work in a hospital pathological laboratory other than your own?

☐ Yes ☐ No

(If yes, complete the attached Exhibit 4)

9. If you are a radiologist, do you work in a hospital X-ray laboratory other than your own?

☐ Yes ☐ No

(If yes, complete the attached Exhibit 5)

10. List hospitals and/or clinics, at which you are applying for staff privileges or have been granted privileges as member of their Medical Faculty?

☐ Yes ☐ No

a: Name_____
Address_____

b: Name_____
Address_____

c: Name_____
Address _____

(If there are more, please list on the attached sheet for additional details)

11. Please list in the attached **Exhibit 6** all institutions (hospital or clinics) you would like SIMED send certificate of insurance if a policy is issued.

12. Do you research, use, administer, or prescribe any drug, pharmaceutical or medical device disapproved or not yet approved for marketing by the United States Food and Drug Administrative for treatment of human beings (including any FDA approved studies/investigations)?

☐ Yes ☐ No

13. Have you signed or will you sign any contract or agreement to assume the liability of others?

☐ Yes ☐ No

(Please be aware that you will not be covered under the policy, if issued, for the liability of others which you have assumed under a contract or agreement.)

14. **Indicate which of the following procedures are performed by you or by an employed physician or surgeon:**

		Applicant		Employed Physician or Surgeon	
		Yes	**No**	**Yes**	**No**
a.	Minor surgery other than incision of boils and superficial fascia, suturing of minor lacerations and removal of superficial skin lesions by other than surgical excision.	☐	☐	☐	☐
b.	Assisting in major surgery on your own patients **If yes, please indicate the name of the doctors you assist and the type of surgeries:** _____	☐	☐	☐	☐
c.	Major surgery	☐	☐	☐	☐
d.	Assisting in major surgery on other than your own patients **If yes, please indicate the name of the doctors you assist and the type of surgeries:** _____	☐	☐	☐	☐

		Applicant		Employed Physician or Surgeon	
		Yes	No	Yes	No
e.	Normal obstetrical procedures not considered major surgery. If you are not obstetricians please indicate bellow on a separate sheet in wish circumstances practice these procedures	☐	☐	☐	☐
f.	Obstetrical procedures considered major surgery*	☐	☐	☐	☐
g.	Abortions	☐	☐	☐	☐
h.	Plastic surgery - reconstructive	☐	☐	☐	☐
i.	Plastic surgery - cosmetic	☐	☐	☐	☐
j.	Spinal surgery	☐	☐	☐	☐
k.	Bariatric Surgery	☐	☐	☐	☐
l.	Administer general anesthesia or acupuncture anesthesia	☐	☐	☐	☐
m.	Pain Management **(If yes, attach the certification issued by the Licensing Board.)**	☐	☐	☐	☐
n.	Acupuncture - other than acupuncture anesthesia **(If yes, attach the certification issued by the Licensing Board.)**	☐	☐	☐	☐
o.	Angiography	☐	☐	☐	☐
p.	Arteriography	☐	☐	☐	☐
q.	Catheterization - arterial, cardiac or diagnostic other than:	☐	☐	☐	☐
	a. Occasional emergency insertion of pulmonary wedge recording catheters or temporary pacemakers b. urethral catheterization, or, c. umbilical cord catheterization for diagnostic purposes or for monitoring blood gasses in newborns receiving oxygen				
r.	Colonoscopy	☐	☐	☐	☐
s.	Cryosurgery	☐	☐	☐	☐
t.	Discograms	☐	☐	☐	☐
u.	Endoscopic retrograde cholangiopancreatography	☐	☐	☐	☐

	Applicant		Employed Physician or Surgeon	
	Yes	**No**	**Yes**	**No**
v. Laparoscopy (Peritoneoscopy)	☐	☐	☐	☐
w. Laser - used in therapy	☐	☐	☐	☐
x. Lymphangiography	☐	☐	☐	☐
y. Myelography	☐	☐	☐	☐
z. Needle Biopsy - including lung, liver, kidney and prostate, but not including bone marrow biopsy	☐	☐	☐	☐
aa. Phlebography	☐	☐	☐	☐
bb. Pneumatic or mechanical esophageal dilation (not with bougie or olive)	☐	☐	☐	☐
cc. Pneumoencephalography	☐	☐	☐	☐
dd. Radiation therapy - The treatment of disease with any type of radiation most commonly with ionizing radiation, including the use of roentgen rays, radium or other radioactive substances	☐	☐	☐	☐
ee. Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	☐	☐	☐	☐
ff. Shock Therapy - The treatment of certain psychotic disorders by the injection of drugs, or by electrical shocks, both methods inducing coma, with or without convulsions including ECT	☐	☐	☐	☐

gg. Other, explain:_____

_____

15. Indicate average number of patients seen daily: _____

16. Indicate average number of surgical procedures performed daily: _____

17. Does your practice entails the provision of services, or the perform once of any procedure, which you have reason to be aware that are usually provided or performed by physicians licensed as specialists or licensed in a specialty different than yours?

If yes, explain in detail:

_____

IV. Claims/Rating Information

The applicant must provide a loss run or loss experience report with all previous insurers. The report must be attached to this application for insurance.

1. Has any claim or suit for any alleged malpractice ever been brought against you?
   ☐ Yes ☐ No

   (If yes, answer the following and complete the attached Exhibit 7.)

   a. How many claims pending? ____
   b. How many claims close without payment? ____
   c. How many claims close with payment? ____

V. Coverage Information

1. Please indicate, on what date do you wish the coverage insurance to be effective (inception date)

   _____ _____ _____
   Mo Day Yr
   12:01 a.m. Standard Time

2. Have you ever practiced without insurance? ☐ Yes ☐ No
   If yes, please explain_____

3. Please provide the following information pertaining to your past years of professional liability insurer:

Policy Number	*From*	*To*	*Retroactive Date*	*Previous Insurance Carrier*	*Policy limits*	*Premium*

4. Do you have an excess or umbrella professional liability or a primary policy in force with other insurance company?

   ☐ Yes ☐ No

   If it is affirmative, please provide Insurer's name _____,

   Policy period_____ _____, Retroactive Date _____,
   From (Mo/Day/Yr) To (Mo/Day/Yr)

   Policy No: ____ Limits of liability _____, and Policy Form No. _____.

5. Have you ever had a professional liability insurance that has been declined, cancelled, issued on special terms, or not renewed? ☐ Yes ☐ No
(If yes, give full details)

_____

_____

VI. Other Underwriting Information	**Yes**	**No**
1. Are you in active United States military service?	☐	☐
2. Are you employed full time by the Federal Government (but not in active United States military service)?	☐	☐
3. Otherwise employed in any capacity by a person or organization on salary or commission? If yes, please indicate by whom: _____	☐	☐
4. Will you be performing activities which will be covered by another professional liability policy? If yes, are you an: ☐ Employee ☐ Independent Contractors ☐ Resident/Fellow ☐ Faculty Location_____Name of Insurer_____		
5. Do you have contract as a provider of the Puerto Rico Government Health Plan?	☐	☐
6. Are you enjoying any kind statutory immunity or any cap in any health facility in which you provide professional services? **If yes, indicate the name and location of the facility and explain.** Name of health facility: _____Location: _____		
7. Do you own or operate any hospital, sanitarium or clinic with bed and board facilities, laboratory, or other business enterprise?	☐	☐
(Please note that you will not be covered for your liability as a proprietor, superintendent, partner, hospital administrator, officer, stockholder or member of the board of directors, trustees or governors of any hospital, sanitarium, clinic with bed and board facilities, nursing home laboratory or other business enterprise) Name of the health care entity:_____		
8. Are you an owner or do you have ownership in a blood bank or laboratory?	☐	☐
(Please note that coverage is excluded for administrative activities unless you are radiologist or pathologist.)		
9. Has your professional license to practice medicine or license to prescribe or dispense narcotics refused, ever been suspended, revoked or restricted, renewal refused or accepted on special terms, or have you ever voluntarily surrounded the same?	☐	☐
10. Have you ever been placed on probation by any licensing board?	☐	☐

		Yes	No
11.	Has any hospital ever denied restricted, suspended or revoked your privileges or placed your on probation?	☐	☐
12.	Have you ever been convicted of a criminal offense other than a motor vehicle violation?	☐	☐
13.	Has your membership in any professional society ever been refused, suspended or revoked?	☐	☐
14.	Have you ever had board certification refused or revoked?	☐	☐
15.	Have you had a problem with or been treated for alcoholism, narcotic addiction or mental illness?	☐	☐
16.	Have you now or have you ever had a chronic illness or physical defect that impairs or could impair your ability to practice your specialty?	☐	☐

If answer to any of the above questions is yes, please give full details on the attached sheet for additional details making reference to the question involved.

IMPORTANT: To consider this application the below certification and release must be signed by the applicant.

CERTIFICATION AND RELEASE

The applicant:

1. **Understands and accepts that this application does not bind the applicant or the Syndicate to complete the insurance, but it is agreed that this form shall be the base of the contract, should a policy (ies) be issued, and it will be attached to and made part of this policy. The applicant agrees that if the information supplied on this application changes between the date of this application and the time when the policy (ies) is issued, the applicant will immediately notify the Syndicate of such change.**

2. **I Understand and accept that signing this application and tendering premium does not bind or obligate the Syndicate to grant the limits of liability of the policy (ies) as requested. If the Syndicate determines that the applicant is eligible for the limits, the corresponding quote indicating the premium will be provided.**

3. **Understands and accepts that the policy (ies) applied for provides coverage on a claims made basis for only those claims that are made against the insured while the policy (ies) is in force, but arising out of a medical incident occurring on or after the retroactive date to be stated in the Declarations Page of the policy (ies), if issued.**

4. **Understands and accepts that coverage ceases with the termination of the policy or policies unless options available are exercised according to its terms.**

5. **Certifies that he or she is duly registered and certified by the corresponding Puerto Rico Board of Medical, Podiatrists for the professional specialty and/or specialties he or she engages in, as indicated in this application and, therefore, understands and accepts that the coverage provided by the policy (ies) applied for is exclusively limited to his or her professional practice pertaining only to the registered specialty to which he/she has been authorized and certified.**

6. **Grants permission to the Syndicate to request information regarding his or her professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which he or she currently has been granted privileges and/or formerly has had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.**

The information requested may include otherwise privileged or confidential material relative to his or her professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the underwriting procedures. The applicant releases and agrees to hold harmless the Syndicate and its representatives, employees and agents which may result from the gathering or legal use of such information to evaluate the issuance of the requested policy (ies).

7. **Hereby authorizes the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which he or she currently has or formerly has had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities and present and past employers to submit information requested by the Syndicate including otherwise privileged or confidential material relative to his or her professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the underwriting procedures. The applicant hereby further releases and agrees to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information.**

8. **Grants permission to the Syndicate to disclose to any institutions as to which I have admitting privileges or other medical relationship, any matter involving a pending or closed claim, cancellation or non-renewal of medical malpractice insurance, or any other matter which could reasonably be expected to affect the interest of such institutions as to any insurance which the Company may provide, and to disclose any information which the Company may be required to disclose by law or regulation.**

9. **Understands that any person who knowingly renders a false report, makes a misrepresentation of facts or includes in any application for insurance any matter which such person knows is untrue, commits a fraudulent act and is in violation of section 12.190 of the Insurance Code of Puerto Rico and certifies that the foregoing answers and statements are complete, true and correct to the best of his or her knowledge and belief.**

AVISO IMPORTANTE

El Articulo 27.320 del C6digo de Seguros de P.R. dispone lo siguiente:

"Cualquier persona que a sabiendas y que con la intenci6n de defraudar presente informaci6n falsa en una solicitud de seguro o, que presentare, ayudare o hiciere presentar una reclamaci6n fraudulenta para el pago de una perdida u otro beneficio, o presentare mas de una reclamaci6n por un mismo dano perdida, incurrira en delito grave y convicto que fuere, sera sancionado, por cada violaci6n con pena de multa no menor de cinco mil (5,000) d6lares, ni mayor de diez mil (10,000) d6lares o pena de reclusi6n por un termino fijo de tres (3) anos, o ambas penas. De mediar circunstancias agravantes, la pena fija establecida podra ser aumentada hasta un maximo de cinco (5) anos; de mediar circunstancias atenuantes, podra ser reducida hasta un minimo de dos (2)".

IMPORTANT WARNING

Article 27.320 of the Insurance Code of P.R. arranges the following:

"Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, or will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with pain of no smaller fine of five thousand (5,000) dollars, nor greater of ten thousand (10,000) dollars or imprisonment by a fixed term of three (3) years, or both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2)".

_____ _____

Applicant's Signature **Date**

Authorized Representative or Broker Name: _____

Telephone Number: _____

Mobile Phone Number: _____

Fax Number: _____

Website Address: _____

Mail Address: _____

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Exhibit 1
Partnership/Corporations

(The professional Liability Coverage Partnership/Corporation will not be provided unless specifically approved by the Syndicate. Review of this application creates no obligation upon the Syndicate. The Syndicate reserves the right to issue a policy to the Partnership/Corp. Liability to provide this coverage. The Partnership/Corp. Liability coverage will be secondary to any professional liability policy that insures any natural or legal person other than the Insured for the loss covered by the Partnership/Corp. Liability policy.)

1. ☐ Single Professional Corp. ☐ Multi-Professional ☐ Partnership
   ☐ Insured by SIMED ☐ Insured by other company

   Give the name and address of the professional partnership or corporation.

   _____

   If it is a partne, include copy of partnership agreement that states the share in the profit and losses of each partner. If it is a corporation, include copy of the certificate and articles of incorporation to this application for insurance. If it's insured by other company, provide the name of the professional liability insurance carrier and the policy number.

   _____

2. Does your partnership or corporation provide services to any health facility ☐ Yes ☐ No
   (If yes, please indicate name(s).

   _____

3. List all partners, members or stockholders that participate with you in the professional partnership or corporation, their specialties, professional licenses, insurance carrier and policy number.

Name	Specialty	Puerto Rico Professional License Number	Insurance Carrier Policy Number

_____ _____ _____
Name of Applicant Signature Date

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Exhibit 2
Employees Information

1. Do you or does your partnership or corporation employ any of the following? **Provide copy of the contract and licenses for each one of your employees, or employees of the partnership or corporation.**

	Number of Employees	Mark with X Employed by		Mark with X If Performs	
		Applicant	Partnership or Corporation	X-Ray Therapy	Shock Therapy
☐ Licensed Physicians					
☐ Licensed Surgeons					
☐ Physician or Surgeon Assistant's					
☐ Licensed Podiatrists					
☐ Laboratory Technicians					
☐ Pathological Technicians					
☐ X Ray Technicians					
☐ Nurse Anesthetists					
☐ Other Nurses					
☐ Surgical Technicians					
☐ Others					

Note: For insurance purposes, a physician or surgeon assistant is one who has completed an approved course of study leading to university certification and who performs his duties under the direct supervision of a licensed physician or surgeon, assisting in the clerical or research endeavors of the physicians or surgeons.

2. If you, your medical partnership or medical corporation employs any health care professionals listed above, please indicate the individual's name, specialty and insurance carrier below:

Name	Professional License No.	Specialty	Insurance Carrier

Provide copy of the contract and licenses for each employed health care professional.

Name of Applicant _____ Signature _____ Date _____

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Exhibit 3

To be completed by Physicians Working in an Intensive Care Unit

☐ On a fee or contract basis
☐ On a salary basis

Name of health care entity gfnfg
What is your position? dhnd

Indicate which of the following procedures or activities you perform:

		Yes	No
a.	Monitoring or management of mechanically ventilated patients.	☐	☐
b.	Continuous EKG monitoring.	☐	☐
c.	Monitoring or management of neurological patients.	☐	☐
d.	Order, management, and administration of medicines to patients with brain trauma.	☐	☐
e.	Catheter insertion for central line access.	☐	☐
f.	Peripheral insertion of central catheter.	☐	☐
g.	Arterial catheterization.	☐	☐
h.	Cardiac catheterization.	☐	☐
i.	Assessment, diagnosis and management of patients critically ill or unstable.	☐	☐
j.	Monitoring transfer of patients to and from the intensive unit.	☐	☐
k.	Lumbar puncture.	☐	☐
l.	Aspiration or bone marrow biopsy.	☐	☐
m.	Administration of intrathecal chemotherapy.	☐	☐
n.	Administration of intrathecal sedation.	☐	☐
o.	Arteriovenous hemofiltration.	☐	☐
p.	Monitoring and management of patients with acute respiratory problems.	☐	☐
r.	Cardiopulmonary resuscitation.	☐	☐
s.	Endotracheal intubation.	☐	☐
t.	Chest tube insertion.	☐	☐
u.	Assisting in surgery.	☐	☐
v.	Assisting during delivery in the operating room.	☐	☐
w.	Assisting during delivery in the delivery room.	☐	☐
X.	Management or administration of moderate or deep sedation.	☐	☐
y.	Monitoring and management of post-surgery patients.	☐	☐
z.	Bronchoscopy.	☐	☐
aa.	Transesophageal echocardiogram.	☐	☐
bb.	Endoscopy.	☐	☐
cc.	Administration of nitric oXide.	☐	☐

Name of Applicant | Signature | Date

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Exhibit 4
Pathologists Information

1. Identify each hospital laboratory or hospital pathological laboratory where you render professional services. Attach a separate list if needed.

_____

_____

_____

2. For <u>each</u> hospital laboratory or hospital pathological laboratory where you render professional services submit a certified statement from the laboratory stating:

(a) the date on which you began providing services;
(b) the total number of pathologists that work at each hospital laboratory or hospital pathological laboratory;
(c) the total number of laboratory technicians that work at each hospital laboratory or hospital pathological laboratory; and
(d) the names of the technicians that you supervise at each hospital laboratory or hospital pathological laboratory.

Each certified statement must be attached to your application for insurance.

3. Have you executed a contract with a hospital to provide hospital laboratory services or hospital pathological services?

☐Yes ☐No

If yes, please attach copy of such contract to your application for insurance.

4. Are you a shareholder, partner, or member of a professional corporation, partnership, or group that has executed a contract with a hospital to provide hospital laboratory services or hospital pathological services?

☐Yes ☐No

If yes, state the name of the professional corporation, partnership or group that has executed such a contract: _____, and attach copy of the contract to your application for insurance.

5. Are you an employee or contractor of another pathologist, or an employee or contractor of a corporation, partnership or group that has contracted with a hospital to provide hospital laboratory or hospital pathological services?

☐Yes ☐No

If yes, attach copy of your employment or services contract to your application for insurance.

Name of Applicant	Signature	Date

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Exhibit 5
Radiologists Information

1. Identify each hospital X-ray unit or X-ray laboratory where you render professional services. Attach a separate list if needed.

   _____
   _____
   _____

2. For each hospital X-ray unit or X-ray laboratory where you render professional services submit a certified statement from the X-ray unit or X-ray laboratory stating:

   (a) the date on which you began providing services;
   (b) the total number of radiologists that work at each hospital X-ray unit or laboratory;
   (c) the total number of X-ray laboratory technicians and X-ray therapy technicians that work at each hospital X-ray unit or laboratory; and
   (d) the names of the X-ray laboratory technicians and X-ray therapy technicians that you supervise at each hospital X-ray unit or laboratory.

   Each certified statement must be attached to your application for insurance.

3. Have you executed a contract with a hospital to provide hospital X-ray services?

   ☐ Yes ☐ No

   If yes, please attach copy of such contract to your application for insurance.

4. Are you a shareholder, partner, or member of a professional corporation, partnership, or group that has executed a contract with a hospital to provide hospital X-ray services?

   ☐ Yes ☐ No

   If yes, state the name of the professional corporation, partnership or group that has executed such a contract: _____, and attach copy of the contract to your application for insurance.

5. Are you an employee or contractor of another radiologist, or an employee or contractor of a corporation, partnership or group that has contracted with a hospital to provide hospital X-ray services?

   ☐ Yes ☐ No

   If yes, attach copy of your employment or services contract to your application for insurance.

Name of Applicant	Signature	Date

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Exhibit 6

List hospital or clinics you would like SIMED sent certificate of insurance:

1. Name_____ Telephone_____

   Mailing Address_____

   E-mail_____

   Contact Name_____

2. Name_____ Telephone_____

   Mailing Address_____

   E-mail_____

   Contact Name_____

3. Name_____ Telephone_____

   Mailing Address_____

   E-mail_____

   Contact Name_____

4. Name_____ Telephone_____

   Mailing Address_____

   E-mail_____

   Contact Name_____

5. Name_____ Telephone_____

   Mailing Address_____

   E-mail_____

   Contact Name_____

Name of Applicant	Signature	Date

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Exhibit 7
Claims Information

Please supply the following information regarding any claims or suit against you weather dismissed, settled out of court, judgment or pending for the past ten years. This form should be photocopied and filled out separately for each claim.

1. Name of Patient _____
2. Allegation _____
   _____
   _____
   _____
   _____
3. Date of incident leading to allegation _____
4. Claim No. an or Civil Case No. _____, _____
5. Date claim was made or filed _____
6. Insurance Company defending you _____
7. Indicate the status or disposition of the Claim or Complaint:

   Pending ☐ (Provide copy of the eXtrajudicial claim or the suit and summons)

   a. Insurer's loss reserve _____Loss adj. expense reserve _____

   Closed ☐

   a. EXact date closed _____
   b. Total settlement or judgment _____
   c. Amount paid on your behalf _____

_____ _____ _____
Name of Applicant Signature Date

SIMED

Sheet for Additional Details

Name of Applicant | Signature | Date