

NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

OHA INSURANCE SOLUTIONS (OHAIS)

155 EAST BROAD STREET, FLOOR 2
COLUMBUS, OHIO 43215
PH. (614) 255-4840 * FAX (614) 255-4839

Requested Effective Date: _____

Note: If any space provided herein is insufficient for complete reply, please use page 15, and/or a separate sheet of paper, identifying by number the questions you answer.

PART I – PERSONAL INFORMATION

Full Name of Applicant: _____ Degree: _____

Date of Birth: _____ Place of Birth: _____

Social Security Number: _____

Home Address: _____

Home Telephone: _____ E-mail Address: _____

PART II – OFFICE INFORMATION

Principal Office Address: _____

Office Telephone: _____ Office Fax: _____

Please check this box if your principal office address is not actually located within the city limits of the city to which your mail is addressed, and indicate the city or county in which your office is located. City County _____

Secondary Office Address: _____

Secondary Office Telephone: _____ Secondary Office Fax: _____

Preferred billing address: Principal Office Secondary Office Home



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

PART III – LICENSING INFORMATION

List all states in which you are licensed to practice medicine.

| State | License Number | % of Practice | County | Member of State Medical Association |
|-------|----------------|---------------|--------|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PART IV – PROFESSIONAL LIABILITY INSURANCE HISTORY

| | | | |
|---------------------------|---------------|--|---|
| Name of Company (Current) | Policy Limits | Period of Coverage: Retroactive Date: | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |
| Name of Company | Policy Limits | Period of Coverage: Retroactive Date: | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |
| Name of Company | Policy Limits | Period of Coverage: Retroactive Date: | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |
| Name of Company | Policy Limits | Period of Coverage: Retroactive Date: | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |
| Name of Company | Policy Limits | Period of Coverage: Retroactive Date: | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |

- If you have been insured under a claims-made policy, are you requesting that the Company provide prior acts coverage? Yes No

If no, did you purchase a reporting endorsement from your current carrier? Yes No
- Have there ever been any gaps in your malpractice coverage? Yes No

If yes, please explain on page 15.
- Has any insurance company ever cancelled, declined to issue, refused to renew, surcharged your premium or issued coverage with any restrictions or exclusions? Yes No

If yes, please explain on page 15.



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

Important information to be used in answering questions IV-4, IV-5 and IV-6 below (including sub-questions):

- The word “claim” refers to:
 - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
- If you answer yes to any of these questions (including sub-questions), please complete the attached Supplementary Claims Information Form (page 16).

4. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? Yes No
5. 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?
- a. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
 - b. A letter from an attorney regarding your medical treatment of a patient? Yes No
 - c. Intra-operative or post-operative complications or other complications resulting in death, paralysis or other significant disabilities? Yes No
 - d. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? Yes No
 - e. Any other circumstances that might reasonably lead to a claim or suit? Yes No
6. Have all circumstances that might reasonably lead to a 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
- a. If yes, how many? _____ Please complete the Supplementary Claims Information Form (page 16) for all such reports.
 - b. If no, please explain on page 15.

Important: If you answer yes to questions 7 through 16, please explain on page 15.

7. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered or otherwise investigated or limited in any way? Yes No
8. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered or in any way restricted? Yes No
9. Have you ever failed any licensing or board certification examinations? Yes No
10. Have you ever been refused hospital privileges? Yes No



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

11. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing board, board of medical examiners or other medical review committee? Yes No
12. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing board, board of medical examiners or other medical review committee? Yes No
13. Have you ever been convicted of a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol? Yes No
14. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? Yes No
15. Have you ever been accused of sexual misconduct of any kind? Yes No
16. Do you have any physical handicap or any chronic illness? Yes No
17. Do you perform consultations utilizing telecommunications technology as the medium for rendering medical services (telemedicine)? Yes No
- a. If yes, please indicate all states in which the patients being treated reside: _____
- b. What percentage of your total practice does telemedicine constitute? _____%
18. If you are a radiologist or pathologist, do you read, interpret or diagnose films, slides or specimens taken of patients who reside outside the state of Ohio? Yes No
- a. If yes, please indicate all states in which the patients being treated reside: _____
19. Are you employed full-time or part-time by the Federal, State, or Local Government? Yes No
- a. If yes, explain the nature of such employment on page 15.
- b. Are you on active duty in the U.S. Military Services? Yes No
- c. Are you a resident, intern or fellow? Yes No
20. Are you engaged in or planning to engage in any "moonlighting" activity? Yes No
- a. If yes, do you desire coverage for your "moonlighting" activities? Yes No
- b. Describe the nature of your "moonlighting" activities on page 15.
21. Do you provide services to any nursing home or similar facility? Yes No
- a. If yes, what percentage of your practice is spent with nursing home patients? _____%
- b. Name(s) and location(s) of nursing home(s) _____
- c. Are you the medical director of the nursing home? Yes No
- i. If yes, is coverage provided by the nursing home facility? Yes No
- ii. If no, who provides the coverage? _____



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

22. Do you, or will you, staff an emergency room? Yes No

a. If yes, how many hours per week? _____

b. Which hospital(s) or for what staffing company will you work?

c. Is this emergency room practice required for staff privileges? Yes No

If yes, submit a letter from your hospital administrator of such requirement and the number of hours you will be staffing the ER.

d. Will you be required to read your own x-rays? Yes No

i. If yes, will they subsequently be read by a radiologist? Yes No

ii. Within how many hours? _____

e. Are you ACLS or ATLS certified? Yes No

f. Will specialists be available at the hospital or on call during your shift to provide back-up for you? Yes No

i. If yes, please list available or on call specialists below.



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

PART V – SURGICAL PRACTICE AND/OR PROCEDURES PERFORMED

Please classify your surgical practice, if applicable:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bariatrics | <input type="checkbox"/> Obstetrics/Gynecology* | <input type="checkbox"/> Otorhinolaryngology |
| <input type="checkbox"/> Cardiac | <input type="radio"/> Normal Deliveries | <input type="radio"/> w/elective cosmetic procedures |
| <input type="checkbox"/> Cardiovascular Disease | <input type="radio"/> C-Sections | <input type="radio"/> w/out elective cosmetic procedures |
| <input type="checkbox"/> Colon and Rectal | <input type="radio"/> VBACS | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> General | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Rhinology |
| <input type="checkbox"/> Gynecology | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Thoracic _____ % |
| <input type="checkbox"/> Hand | <input type="radio"/> Spine Surgery | <input type="checkbox"/> Vascular _____ % |
| <input type="checkbox"/> Head and Neck | <input type="radio"/> No Spine Surgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Laryngology | <input type="checkbox"/> Otology | <input type="checkbox"/> Other (list): _____ |
| <input type="checkbox"/> Neurology | | |

* If you are applying for coverage for an obstetrical practice, do you have privileges to perform C-sections at each hospital you staff? ___ yes ___ no

Important: If no, please provide full details of your back-up arrangements on page 15.

Please check any of the following procedures you will perform:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortions | <input type="checkbox"/> Dermatological Surgery | <input type="checkbox"/> Mammography |
| <input type="checkbox"/> Acupuncture | <input type="radio"/> Chemical peels | <input type="checkbox"/> Myelography |
| <input type="checkbox"/> Adenoidectomy | <input type="radio"/> Chemobrasion | <input type="checkbox"/> Norplant Insertion/Extraction |
| <input type="checkbox"/> Alternative Medicine | <input type="radio"/> Dermabrasion | <input type="checkbox"/> Organ Transplant |
| <input type="radio"/> Herbal Therapy | <input type="radio"/> Hair Transplant | <input type="checkbox"/> Pain Management |
| <input type="radio"/> Other _____ | <input type="radio"/> Silicone Injections | <input type="radio"/> Medication Only |
| <input type="checkbox"/> Anesthesia | <input type="radio"/> Tumescant Liposuction | <input type="radio"/> Nerve Block |
| <input type="radio"/> Spinal | <input type="radio"/> Other _____ | <input type="radio"/> Implants |
| <input type="radio"/> Caudal | <input type="checkbox"/> D&C | <input type="radio"/> Radiofrequency Procedures |
| <input type="radio"/> General | <input type="checkbox"/> Encephalography | <input type="radio"/> Other _____ |
| <input type="radio"/> Local | <input type="checkbox"/> Endoscopic Laser Therapy | <input type="checkbox"/> Permanent Pacemaker |
| <input type="radio"/> Other _____ | <input type="checkbox"/> Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> ERCP | <input type="checkbox"/> Radiation/X-Ray Therapy |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Exchange transfusions in newborns | <input type="checkbox"/> Radiopaque Dye |
| <input type="checkbox"/> Appendectomy | How many per year? ___ | <input type="checkbox"/> Renal Analysis |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Fracture Reductions | <input type="checkbox"/> Shock Therapy |
| <input type="checkbox"/> Assist in Major Surgery | <input type="radio"/> Open | <input type="checkbox"/> Tonsillectomy |
| <input type="radio"/> On Own Patients | <input type="radio"/> Closed | <input type="checkbox"/> Weight Control |
| <input type="radio"/> On Patients of Others | <input type="checkbox"/> Hip Nailings | ___% of Practice |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Hyperbaric Medicine | <input type="radio"/> Gastric Bubble |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Intensive Care for Newborns within a Tertiary Care Unit | <input type="radio"/> Gastric Stapling |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Medications Prescribed |
| ___% Cosmetic | <input type="checkbox"/> Laser Surgery | _____ |
| ___% Reconstructive | <input type="checkbox"/> Left Heart Catheterization | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemonucleolysis | <input type="checkbox"/> Liposuction | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Other Procedures (list): _____ |
| <input type="checkbox"/> Cholecystectomy, Laparoscopic | | _____ |
| <input type="checkbox"/> Colonoscopy | | _____ |
| <input type="checkbox"/> Cryosurgery (other than external lesions) | | _____ |

NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

PART VI – COVERAGE INFORMATION

Coverage Limits Offered: \$1,000,000 Per Claim/\$3,000,000 Annual Aggregate

Coverage Type Offered: Claims-Made

Requested Effective Date: _____ Requested Retroactive Date: _____

Coverage will become effective upon the completion of all underwriting functions and acceptance by the Company.

PART VII – RATING INFORMATION

1. What is your present specialty? _____
2. What is your present sub-specialty? _____
3. What percentage of your practice is devoted to your specialty? _____%
4. What percentage is devoted to your sub-specialty? _____%
5. Have there been any changes in your specialty, classification or practice activity within the past ten years? Yes No
If yes, explain the nature of the changes on page 16.
6. Are you American Board Certified? Yes No
 - a. If yes, list specialty board: _____, date of board certification: _____
 - b. If no, are you board eligible? Yes No
If board eligible, when do you plan to take your boards? _____
7. Indicate the average number of patients seen per week: _____
8. Indicate the number of hours practiced per week: _____ (include on-call hours)
9. If applying for obstetrical coverage, indicate the average number of deliveries performed per year: _____
10. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by/responsible to an anesthesiologist? Yes No
 - a. If yes, explain the nature and percentage of your surgery or the average number of cases per month:



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

PART VIII – MANAGED CARE CONTRACT INFORMATION

| Name of Managed Care Organization | Approximate % of Total Patients | Capitated? |
|-----------------------------------|---------------------------------|--|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PART IX – EDUCATION INFORMATION

| Medical School Data | | | |
|--|--|--------|----------------|
| Name of Medical School(s) | Location of Medical School(s) Attended | Degree | Date Graduated |
| | | | |
| | | | |
| | | | |
| If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| Residencies, Internships, Fellowships, Preceptorships | | | | | |
|--|----------|------------|--------------------|-----|--|
| Hospital Data | | | Dates (Month/Year) | | Completed |
| Name | Location | Department | Start | End | |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If a residency, internship or fellowship was not completed, please explain on page 15. | | | | | |



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

| Other Medical Education (Category I CME Programs) Completed in the past three years. | | |
|---|-----------------------------|---|
| Courses Completed | CME Credits Received | Dates(s) Attended Month/Year |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

PART X – PRACTICE HISTORY

| Please list locations where you have practiced since residency | | |
|---|---------------------------|------------|
| Location | Dates (Month/Year) | |
| | Start | End |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Explain any gaps in practice on page 15.

PART XI – HOSPITAL AFFILIATIONS AND PRIVILEGES

| Hospitals where you have, or have had, active privileges | | | | | |
|---|------------------------------|-------------------|-------------------------------|------------|---|
| Hospital Data | | | Dates (Month/Year) | | % Patients Admitted to this Facility |
| Name | Location (City/State) | Department | Start | End | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

| Hospitals where you have applied for privileges, but have not yet been accepted | | | | | |
|--|------------------------------|-------------------|-------------------------------|------------|--|
| Hospital Data | | | Dates (Month/Year) | | % of Patients Admitted to this Facility |
| Name | Location (City/State) | Department | Start | End | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Hospitals where you have been denied privileges | | | |
|--|--|-------------------|-------------------------------------|
| Name | Hospital Date Location (City/State) | Department | Date Denied (Month/Year) |
| | | | |
| | | | |
| | | | |

Explain any denial of privileges on page 15.

PART XII – PRACTICE ORGANIZATION

1. Coverage Desired for: (check all that apply)

Solo Entity: Name _____
 Separate Limits Shared Limits

Member of a partnership or multi-shareholder corporation:
 Partnership/Group Name _____
 Separate Limits Shared Limits

Other (i.e., implied partnership, corporation, etc.):
 Entity Name _____
 Separate Limits Shared Limits

2. Give the full names of all other physicians affiliated with any organization(s) named in Question XIII. All physician members or employees must complete a separate application if organization coverage is to be provided. Use page 15 and/or additional sheet if needed.

| Name | Current Medical Professional Insurance Co. |
|-------------|---|
| | |
| | |
| | |
| | |



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

PART XIII – INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

The following is a list of “allied health care professionals” for which a separate charge may be required:

CRNA, Cytotechnologist, Emergency Medical Technician, Nurse Practitioner, Nurse Midwife,
Optometrist, Perfusionist, Physician’s Assistant, Psychologist and Surgeon’s Assistant.

1. List all such allied health care professionals who provide services in your office as employees:

| Name | Specialty | Check Desired Limits |
|------|-----------|---|
| | | <input type="checkbox"/> Separate <input type="checkbox"/> Shared |
| | | <input type="checkbox"/> Separate <input type="checkbox"/> Shared |
| | | <input type="checkbox"/> Separate <input type="checkbox"/> Shared |
| | | <input type="checkbox"/> Separate <input type="checkbox"/> Shared |
| | | <input type="checkbox"/> Separate <input type="checkbox"/> Shared |

2. Do you or any member of your group currently supervise an “allied health care professional” (as defined above) who is not in your employ? Yes No
Do you plan to do so in the future? Yes No

3. Indicate the number of the following types of other individuals who provide services in your office as employees:

| Number | Position | Number | Position |
|--------|-------------------|--------|---|
| | Medical Assistant | | Nurse (Registered or Licensed Vocational) |
| | Psychotherapist | | Technician (Lab, Pathological, Dialysis) |
| | X-Ray Technician | | Other |

PART XIV – ADDITIONAL DATA

1. Do any of your employees (not including physicians) practice at a location geographically separate from you? If yes, please explain on page 15. Yes No
2. Do you, or does any partnership or corporation of which you are a member or shareholder, own or operate a surgicenter, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice? If so, please describe on page15. Yes No
3. Do you perform medical or surgical procedures at a surgicenter or similar facility? If so, please provide the names of the facilities, describe the types of procedures, and provide approximate distance to the nearest hospital on page15. Yes No



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

**SPECIFIC CONSENT
TO CONDITIONS OF CONSIDERATION OF THE APPLICATION FOR INSURANCE**

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application - regardless of whether or not I am granted insurance - and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection or approval for insurance, and any communications, reports, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed medical doctor who makes application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

The information provided on this application and on any supplementary attachments is complete and correct to the best of my knowledge.

Fraud Warning: Any person who, with intent to defraud or knowledge 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.

Applicant's Signature

Date

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following page of this Application is an *Authorization To Release Information* form which requires your signature. Please read carefully.



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by OHA Insurance Solutions (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 his 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 or managed care entities in which he now holds or has held staff privileges or has been otherwise credentialed, the State Board of Medical Examiners for the State of Ohio and any other state in which he has practiced, or resided, and any and all physicians 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 his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above and their agents, servants and employees, and the Company, its 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 persons and organizations 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 organizations 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 organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Applicant's Name (printed)

Applicant's Signature

Date

VERY IMPORTANT: The following information must be submitted with your completed application.

1. Ten years of loss history (current carrier loss runs)
2. Copy of current declaration/summary page
3. Copy of current business letterhead



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

NO KNOWN CLAIMS DECLARATION

I declare that I am not aware of, nor do I have any knowledge of, any claim or incident, any unreported conduct, or any circumstance or occurrence which could reasonably be expected to result in a claim against me subsequent to the date of my signature below that I have not already reported to my previous professional liability carrier and which I have not disclosed on my application to OHA Insurance Solutions (OHAIS).

I have reported all claims and all facts or circumstances that could give rise to a claim to appropriate prior carrier(s) and understand that all such known claims or potential claims will not be covered by this insurance. I also understand that this insurance does not apply to any of the following:

Any incident or claim for which I have received notice of a claim.

Any incident or claim for which a legal action has been filed against my employees or me.

Any incident or claim upon which any companies previously insuring me have previously established a claim file.

Any incident or claim arising out of any fact, circumstance or situation indicating the possibility of a claim, which was known to me as of the effective date of insurance for which I am applying.

Applicant's Name (printed)

Applicant's Signature

Date

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 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.

This may be revoked by me at any future time by sending written notice to: OHA Insurance Solutions, Inc. at 155 E. Broad Street, Floor 2, Columbus, Ohio 43215.

Applicant's Signature



NEW BUSINESS APPLICATION FOR PHYSICIANS AND SURGEONS

PHYSICIANS' & SURGEONS' SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? YES NO

8. Status of claim (check applicable answer)

- | | | |
|--|--|--|
| <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Suit settled out-of-court | <input type="checkbox"/> Awaiting mediation |
| <input type="checkbox"/> Suit filed, but dropped by claimant | Date claim paid _____ | <input type="checkbox"/> Awaiting court action |
| <input type="checkbox"/> Summary judgment in our favor | Amount paid: _____ | Reserve Amount: _____ |
| | Did you want to settle this claim? | |
| <input type="checkbox"/> Court outcome in your favor | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Jury Verdict | | |
| <input type="checkbox"/> Directed Verdict | <input type="checkbox"/> Court outcome in favor of plaintiff | |
| | <input type="checkbox"/> Jury Verdict | |
| | <input type="checkbox"/> Directed Verdict | |

9. Name and address of the attorney assigned to your case: _____

10. To your knowledge, was any settlement paid by another party involved (i.e. your P.A., P.C., partners, employees, etc.?) YES NO
If yes, amount was: \$ _____

Applicant's Name (printed)

Applicant's Signature

Date

