

IMPORTANT: Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers. If additional space is required, please use the "Remarks" section at the end of the application.

1. Name: _____ Policy/Reference No. _____

2. Effective date of change: _____ Desired limits of liability _____

3. Principal office address: _____
street city, state, zip telephone #

4. Other practice locations: _____
street city, state, zip telephone #

Home address: _____
street city, state, zip telephone #

5. Principal medical specialty or subspecialty: _____

6. Your practice is: Full Time Part Time If P/T, total number of hours: _____
(Include hospital rounds, charting, patient visits/consults, and phone contact and on-call hours involving patient contact.)

7. Are you leaving a group? Yes No If "Yes," which group? _____

Is this group requiring you to purchase the Extended Reporting Endorsement? Yes No

Last day of employment: _____

8. Are you joining a group? Yes No If "Yes," which group? _____

Is this group willing to purchase your prior acts? Yes No

First day of employment: _____

Your relationship with the group i.e. employee, *independent contractor, partner, shareholder:

9. If joining a group, should we send your billing statement to the clinic? Yes No

10. If you are not joining a group, describe your practice, i.e. individual (solo unincorporated), *independent contractor:

11. Do you have another position for which PI coverage is not required? Yes No

If "Yes," please describe: _____

12. Do you practice (other than strictly call-sharing arrangement) with any physicians who are not insured by Physicians Insurance?

Yes No

If "Yes," please indicate name(s) of physician(s): _____

*Remark: Please submit a copy of your written contract

13. How many of the following support personnel are employed or contracted by you at your new location?
 (if you are a member of a partnership or corporation, this does not apply):

- | | | |
|-------------------------------|------------------------------------|-------------------------------|
| _____ RN/LPN | _____ Medical Assistant | _____ Lab/X-Ray Technician |
| _____ Bookkeeper/Receptionist | _____ Licensed Surgical Assistant | _____ Nurse Practitioner |
| _____ CRNA | _____ Licensed Physician Assistant | _____ Certified Nurse Midwife |
| _____ Other (please describe) | | |

14. Please list all hospitals where you currently hold and/or are applying for privileges at:

<u>Hospital</u>	<u>Status</u>	<u>Send Confirmation of Coverage (Y or N)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Please list any partnership, corporation, billing service, managed care organization, IPA, PPO, PHO or MSO that you are associated with, and in what capacity (i.e., employee, partner, shareholder, associate, independent contractor, member or provider):

16. Volume of practice:

- Number of patients seen by you in office: _____ per week
 Number of patients seen by you in hospital: _____ per week
 Number of patients seen only by support personnel employed by you: _____ per week

17. Will there be any material changes in your practice that may affect your rating (e.g.: assisting at surgery on other than your own patients, performing minor surgery, major surgery, abortions, obstetrics, practice hours, etc.)? If so, please describe below and attach any additional training or continuing education materials if necessary:

18. Will you be performing the following (Please check medical techniques you perform):

- | | |
|---|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Neuro-otological surgery |
| <input type="checkbox"/> *Alternative or Complementary Medicine | <input type="checkbox"/> MOHS technique |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Open Reduction of Fractures |
| <input type="checkbox"/> Appendectomies | <input type="checkbox"/> Other Visualization of Internal Organs |
| <input type="checkbox"/> Assisting surgeries other than own patients _____% of practice | Please describe: _____ |
| <input type="checkbox"/> *Bariatric _____% of practice | <input type="checkbox"/> *Pain Management _____% of practice |
| <input type="checkbox"/> Body Imaging (non medical referral) _____% of practice | Please describe: _____ |
| <input type="checkbox"/> Botox Injections (for cosmetics) | <input type="checkbox"/> Plastic Surgery Procedures, please describe: _____ |
| <input type="checkbox"/> Chemical peel (Baker or Phenol) | <input type="checkbox"/> Psychosomatic Medicine _____% of practice |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Refractive Surgeries _____ number/month |
| <input type="checkbox"/> Cosmetic Procedures | Please describe in Remarks section any other ophthalmologic plastic surgery procedures |
| <input type="checkbox"/> Deep radiation / X-ray therapy (over 120 k.v.) | <input type="checkbox"/> Right Heart Catheterization (other than Swan-Ganz) |
| <input type="checkbox"/> Diagnostic Embolization | <input type="checkbox"/> Scalp Reduction |
| <input type="checkbox"/> Dilation and Curettage | <input type="checkbox"/> Shock Therapy |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Transluminal Angioplasty |
| <input type="checkbox"/> Epidural Injection | <input type="checkbox"/> T&A |

- Hair Transplants
- Hemorrhoidectomies
- Herniorrhaphies
- Hysterectomies
- Injection of Radiopaque Dye (other than IVP, CAT scans, & MRI)
- Laparoscopy
- Laser Procedures _____ # / month
- LASIK _____ # / month
- Left Heart Catheterization
- Level III Neonatal intensive care nursery _____ % of practice
- Liposuction _____ cc of fat removed

- Tubal Ligation
- Urgent Care _____ (% of practice)
Percentage of return patients _____%
- Vasectomies
- Virtual Medicine
- Weight-reduction Drugs
Name of medication _____ Percentage of patients _____%
- *Telemedicine
- *Teleradiology
- Other Procedures: _____

If you do not perform any of the above, please check here

Remarks: Further documentation or supplementary questionnaire maybe required for procedures with "*" .

Note: If you answer "Yes" to any of the following questions, please describe on page 4 in the "Remarks" section.

1. Has your license to practice medicine or dispense narcotics in any jurisdiction ever been limited, denied, revoked, suspended, or voluntarily surrendered or subjected to probationary conditions, or have proceedings towards any of those ends been instituted against you?
Medical License Yes No
DEA License Yes No

2. Have any complaints ever been filed against you with a governmental agency, medical or professional society, or other medical entity?
Yes No

3. Have you ever been subject to a governmental agency, medical or professional society, or other medical entity's disciplinary proceedings or reviews, or have you ever been notified of intent to pursue such action?
Yes No

4. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification of your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by such agency or society? Yes No

5. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No

NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.

6. Have you ever been charged or convicted of a felony? Yes No

7. Have you ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital, or has any hospital notified you of its intent to pursue such action? Yes No

8. Have your hospital privileges ever been restricted, suspended, revoked, non-renewed or denied, or has any hospital notified you of its intent to pursue such action? Yes No

9. Has the threat or avoidance of disciplinary action ever caused you to voluntarily relinquish a medical staff membership, clinical privilege, professional license, or narcotics registration? Yes No

10. Has any professional liability insurance carrier ever declined, cancelled, refused renewal, or issued coverage on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature? Yes No

11. Have you ever been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? Yes No

12. Have you ever incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, hearing or vision impairment, Hepatitis B or C, HIV)? Yes No

If "Yes," in the "REMARKS" section, state illness or disability with date(s), and provide the name of and a statement from your treating physician attesting to your fitness to practice your profession.

13. Has **any** claim or suit for alleged malpractice ever been brought against you or your professional corporation that has not already been reported to Physicians Insurance? Yes No

If "Yes," give full details on the Claim Information Supplement, which is attached as part of this application, for ALL claims even if closed for no payment.

14. Have you ever been accused of sexual misconduct? Yes No
15. Have you ever had contact of a sexual nature with a patient or former patient? Yes No

CLAIM INFORMATION

(NOTE: please make copies of this form for additional claims)

No claims. A signature is required regardless of claims history.

1. Name of patient: _____ 2. DOB: _____ 3. Sex: _____

4. Allegation: _____

5. Date of incident: _____ 6. Date reported: _____

7. Insurance carrier: _____

Was a lawsuit filed? Yes No

8. Additional defendants: _____

9. Location of occurrence: _____

10. Disposition of claim: _____

11. Amount of settlement or judgment: _____

If claim is still open, reserve amount: _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.

12. Condition and diagnosis at time of incident: _____

13. Date and description of treatment rendered: _____

14. Condition of patient subsequent to treatment: _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Applicant's Signature*

Date

** Signature line must be signed and dated even if you have no claims to report.*

POLICYHOLDER'S AUTHORIZATION AND RELEASE

(Please read carefully)

I acknowledge that as a condition of updating my application with Physicians Insurance, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I authorize Physicians Insurance to conduct any such inquiry and investigation and authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges, or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, the Washington Physicians Health Program, any prior professional liability insurance carriers, prior employers or professional associates, and Physicians Insurance or its duly authorized representatives. I further release Physicians Insurance and any party responding to an inquiry by Physicians Insurance from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures, and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives.

Policyholder's signature

Date

Washington State law requires us to inform you of the following: 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.

(A photocopy of this Authorization shall be considered as effective and valid as the original.)

Please return to:

Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
1730 Minor Avenue, Suite 1800
Seattle, WA 98101
(206) 343-7300 (800) 962-1399

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398

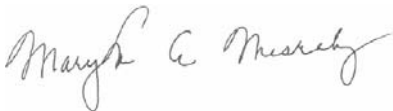


Business Associate Agreement

Effective April 14, 2003, the Physicians Insurance Companies (which include Physicians Insurance A Mutual Company, Western Professional Insurance Company, and Northwest Dentists Insurance Company, all of which are known collectively as "the Company") are committed to complying with the duties of a business associate of a covered entity as set out in the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under the Privacy Regulations, each insured of the Company is a "covered entity," and pursuant to 45 C.F.R. §164.502(e) and 45 C.F.R. §164.504(e), the Company is a business associate of each of its insureds. The Company must receive, use and/or disclose Protected Health Information in order to perform services to its insureds. The Company agrees to abide by the assurances, terms, and conditions contained herein in the performance of its obligations. This Agreement sets forth the terms, conditions, and obligations pursuant to which Protected Health Information that is provided by or to, or created or received by, the Company from, or on behalf of, its insureds will be handled. The Company agrees as follows:

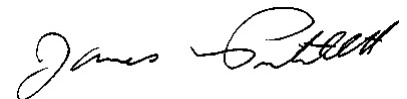
- A. **Permitted Uses and Disclosures of Protected Health Information.** Pursuant to this Agreement and the insurance policies it issues, the Company provides services ("Services") for each insured's operations that involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, quality assessment, quality improvement, outcomes evaluation, protocol and clinical guidelines development, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs to improve the skills of health care practitioners and providers, credentialing, conducting or arranging for medical review, arranging for legal services, managing claims, 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, the Company may make any use of Protected Health Information necessary to perform its obligations under this Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, the Company may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to its employees, subcontractors, and agents, in accordance with Section B (4) below; (ii) as directed by the insured; or (iii) as otherwise permitted by the terms of this Agreement. Additionally, unless otherwise limited herein, the Company is permitted to make the following uses and disclosures:
- (1) **Business Activities of the Company.** The Company may:
 - (a) Use the Protected Health Information in its possession for its proper management and administration and to fulfill any present or future legal responsibilities of the Company provided that such uses are permitted under state and federal confidentiality laws, and
 - (b) Disclose the Protected Health Information in its possession to third parties for the purpose of its proper management and administration or to fulfill any present or future legal responsibilities of the Company provided that (i) the disclosures are required by law; or, (ii) the Company has received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 C.F.R. §164.504(e)(4).
 - (2) **Additional Activities of the Company.** In addition to using the Protected Health Information to perform the services set forth above, the Company may:
 - (a) Aggregate the Protected Health Information in its possession with the Protected Health Information of other covered entities that the Company has in its possession through its capacity as a business associate to said other covered entities provided that the purpose of such aggregation is to provide insureds with data analyses relating to their health care operations. Under no circumstances may the Company disclose Protected Health Information of one covered entity as defined by 45 C.F.R. Parts 160 and 164 to another covered entity absent explicit authorization; and,
 - (b) De-identify any and all Protected Health Information provided that the de-identification conforms to the requirements of 45 C.F.R. §164.514(b), and further provided that the insured is sent the documentation required by 45 C.F.R. §164.514(b), which shall be in the form of a written assurance from the Company. 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.
- B. **Responsibilities of the Company.** With regard to its use and/or disclosure of Protected Health Information, the Company hereby agrees to do the following:
- (1) Use and/or disclose the Protected Health Information only as permitted or required by this Agreement or as otherwise required by law;
 - (2) Report to the designated Privacy Officer of the named insured, in writing, any use and/or disclosure of the Protected Health Information that is not permitted or required by this Agreement of which the Company becomes aware within 10 business days of the Company's discovery of such unauthorized use and/or disclosure;

- (3) Use commercially reasonable efforts to maintain the security of the Protected Health Information and appropriate safeguards to prevent unauthorized use and/or disclosure of such Protected Health Information;
- (4) Require all of its subcontractors and agents that undertake to perform the services that the Company performs under this Agreement and that receive or use, or have access to Protected Health Information under this Agreement to agree, in writing, to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to the Company pursuant to this Agreement;
- (5) Unless prohibited by attorney-client and other applicable legal privileges or unless it would violate the Company's contractual and other legal obligations to the insured, make available all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to the Secretary of HHS for purposes of determining the insured's compliance with the Privacy Regulations;
- (6) Upon prior written request, make available during normal business hours at the Company's offices all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to the insured within five (5) business days for purposes of enabling the insured to determine the Company's compliance with the terms of this Agreement;
- (7) The Company shall honor any request from an insured for information to assist in responding to an individual's request for an accounting of disclosures of Protected Health Information to the Company. However, should the insured be asked for an accounting of the disclosures of an individual's Protected Health Information in accordance with 45 C.F.R. §164.528, such accounting should not include any disclosures to the Company which were to carry out the insured's health care operations. See 45 C.F.R. §164.528(a)(1)(i).
- (8) Upon termination of the insurance coverage of the insured, the protections of this Agreement will remain in force and the Company shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of its business or as required by law.
- (9) In those rare instances when the insured would be required to honor an individual's request for access and/or amendment of protected health information disclosed to the Company, the Company will assist the insured to comply with its duties under 45 C.F.R. §§ 164.524 and 164.526. However, usually the insured will not be required to honor such requests because protected health information in the Company's possession is not part of a designated record set as that term is defined by 45 C.F.R. § 164.501; and/or because the information is exempt from access and amendment under 45 C.F.R. §§ 164.524(a) and 164.526(a)(2); and/or because access would violate superceding contractual and other legal rights of the insured; and/or because any amendment could be tampering with evidence in a civil or administrative matter.
- (10) The Company shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information the Company creates, receives, maintains or transmits on behalf of the insured. Pursuant to paragraph B. (2) above, the Company shall notify the designated privacy officer of any security incident (as that term is defined at 45 CFR Sec. 164.304) of which it becomes aware.
- (11) The insured may terminate this agreement by canceling the insurance policy if the Company violates a material term of this agreement.



Mary-Lou A. Misrahy

*President and Chief Executive Officer
Physicians Insurance A Mutual Company*



James W. Pritchett, MD

*Chairman of the Board of Directors
Physicians Insurance A Mutual Company*

KEEP IN YOUR BUSINESS ASSOCIATE CONTRACT FILE