ACADEMIC MEDICAL PROFESSIONALS INSURANCE
EXCHANGE RISK RETENTION GROUP

Academic Medical Professionals Insurance Exchange – Risk Retention Group ("Exchange")
Application for Non-Standard Program Membership and Insurance

Name	Social Security ___ ___ ___-___ ___ - ___ ___ ___ ___
Mailing Address: (All Formal Notices Will Be Sent To This Address) Institution	Box No.
Street	City/State/Zip
Home Address Street	City/State/Zip
Business Phone	Fax
Home Phone	Business E-Mail

Personal Profile

Date and Country of Birth_____
Professional Schools Attended_____
Degree Received/Date of Graduation_____
Residency Location /Date of Program_____
Specialty_____
Sub-specialty_____
Board Certified In_____
Medical License Number (New York)_____
Other States Licensed_____

Note: Please include a copy of your CV with this application.

1. Please list all hospitals (for the past five years) where you have had, or expect to have staff membership or privileges:

Name of Hospital/City, State	Active Staff or Courtesy	Will this hospital indemnify you?

2. This application is for a program of insurance that may require an intensive risk management analysis and loss prevention plan. To be eligible for this program you agree to the following:

i. to cooperate with the Exchange by giving access and all necessary assistance to its assigned practice field investigators;
ii. to give your permission to the Exchange's underwriting staff to discuss any prior or current claims with your prior insurers, defense counsel or plaintiff's counsel; and
iii. to make yourself available to, and to fully discuss the clinical aspects of your medical practice with the peer faculty physician(s) and surgeon(s) that may be assigned by the Exchange to assist in the development of a loss prevention plan for you.

The Exchange, AHPIA Solutions, Inc. and its reinsurers cannot warrant that any risk management analysis or plan will succeed in improving your loss experience or reduce your premiums. Improvement will depend on a variety of factors, some of which may not be within the Exchange's or the Insured's control. Please confirm to the terms set forth in Paragraph 2 by initialing by here:_____

Assignment Agreement

a. Do you have you an agreement with a third party assignee to pay the contributions to surplus assessments and premiums required by the Exchange on your behalf? (Yes _____No _____). If yes, have you also agreed to return any distributions and unearned premium to this third party (Yes _____No _____). If you answered yes to any part of the above, please provide the name of your assignee in the space provided below before signing.

Limited Power of Attorney

I authorize the Exchange to directly bill all invoices for my premium and other obligations to my assignee:

Name of Assignee:_____
Print

Current Practice

Medical/Dental Specialty:	Sub-Specialty:	% of Practice:
Average Weekly Patient Load: Hours of Practice per week:	% of Practice Out of State	% Locum Tenens:

3. a. Number of years at current location: _____

b. Have there been any significant changes in your practice during the past five years, i.e. change of Specialty, addition or deletion of procedures, etc. Yes _____ No _____

If "YES" please explain (attach additional documentation, if necessary)

_____
_____
_____

c. Type of Practice

Self-employed? Yes _____ No _____
An employee of another physician Yes _____ No _____
An employee of an organization, other than a hospital, engaged in the delivery of medical services Yes _____ No _____
An independent contractor to an organization other than a hospital, engaged in the delivery of medical services Yes _____ No _____

d. Are you a partner, stockholder or employee in a Medical Partnership, PA or PC? Yes _____ No _____
Are you requesting that the legal entity be named as an additional insured on your policy? Yes _____ No _____
(If the Exchange does not insure all the members, the coverage extended to the corporation would respond only to liability arising out of the acts of the insured physician).

e. Do you practice medicine as an employee or consultant to any governmental body? Yes _____ No _____
If yes, name of government body: _____

Clinical Role _____ Percent of Practice _____ Number of Hours per Month _____

f. Do you work for one or more Free-Standing, Walk-In, or Hospital Emergency facility? Yes _____ No _____

How many Emergency Departments? _____ Percent of Practice _____ Number of Hours per Month _____

Name of Contract Group or Hospital	Duties

Total emergency procedures performed per year: _____

Medical Staff

4. a. Do you personally employ any of the following support personnel? Include number of employees by category:

Med Lab Tech	LPN/LVN	X-Ray Tech
Pharmacist	RN	Physiotherapist
Scrub Nurse	Optometrist	Psychologist
Med Assistant	Optician	Other

Indicate the number of employed by you or your group:

Midwife	Physician/Surgeon Assistant	Paramedic
CRNA	Nurse Practitioner	OR Tech

b. Are any of the above independent contractors? Yes _____ No _____

c. If independent contractors, do they have individual coverage independent of you? Yes _____ No _____

Medical Procedures

5. Indicate the extent of surgery you perform:

___ No surgery except incision of boils, cysts, other superficial abscesses or suturing of minor lacerations
___ Assisting in surgery on your own patients — Number Annually _____
___ Assisting in surgery on patients other than your own — Number Annually _____
___ Minor Surgery — Number Annually _____
___ Normal obstetrical deliveries — Percent Cesarean Sections _____ — Number Annually _____
___ Major Surgery – includes all procedures done under general, spinal or caudal anesthesia. — Number Annually _____

Indicate the following procedures which you perform and specify whether Primary (P) or Assisting (A). If none, check here ____

Abortions	Gastric Stapling	Open reductions of fractures
Acupuncture or acupressure	General Anesthesia	Radial keratotomy
Anesthesia (spinal in children)	Hair growing or transplants	Radiation therapy
Angiography	Banding hemorrhoids	Shock Therapy (ECT)
Appendectomies	Hemorrhoidectomy	Spinal anesthesia
Cesarean Sections	Hernias	Suction assisted lipectomy/liposuction
Chemabrasion	Hysterectomies	T & A's
Colonoscopy	Injection or implants (breasts)	Thoracic Surgery
Cosmetic plastic surgery (elective)	Insertion of intrauterine contraceptive devices	Tubal ligations
Cosmetic plastic surgery (traumatic)	Neurological Surgery	Vascular surgery (other than peripheral vascular
Cryosurgery	Orthopedic Surgery	Vasectomies
D & C's	Needle biopsy	Weight control other than diet
Dermabrasion	Obstetrical Deliveries	Any procedure not usual or customary to the specialty
Endoscopic procedures	OB deliveries at other than a licensed acute care hospital	Laparoscopic Procedures
Gastric by-pass surgery	Office x-rays	Experimental procedures (include explanation)

Additional Professional Information

6. a. Has membership in any professional association or society ever been revoked or refused? Yes _____ No _____
Has any hospital suspended, restricted or refused your staff privileges, or have you voluntarily or involuntary surrendered or limited your privileges any time while under peer investigation? Yes _____ No _____
Have you ever had a grievance filed against you with your County or State Medical Society (OPMC or DOH), or have you been censured in any way as a result of this? Yes _____ No _____
Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended or revoked? Yes _____ No _____
Have you ever been treated for alcoholism, narcotic addiction, or mental illness? Yes _____ No _____
Have you ever been convicted of a felony? Yes _____ No _____
Have you ever suffered from or been treated for any chronic illness or physical defect? Yes _____ No _____
Have you ever had any professional liability insurance refused, cancelled or non-renewed? Yes _____ No _____
Do you work as an emergency room physician? Yes _____ No _____
If yes, how many hours per week: _____
Do you work in an industrial clinic? Yes _____ No _____
Do you work in any free-standing Birthing Center or similar facility? Yes _____ No _____

b. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer of any of the following: Hospital, Sanitarium, Nursing Home, Surgi-Center, Clinic with bed and board facilities Laboratory (independent or outside), Blood Bank, Prepaid Health Plan or Health Maintenance Organization, or other medical facility. Yes _____ No _____

If yes, please list the names of the facilities and your affiliation with them in the space provided:

_____

_____

c. Do you practice medicine at this/these institution(s)? Yes _____ No _____

If yes, please explain:

_____

_____

_____

_____

d. Additional Professional Information (continued):

Do you maintain any overnight patient facilities in your own office?	Yes _____	No _____
Do you render patients unconscious for treatment in your office or other non-hospital facility?	Yes _____	No _____
Do you ever enter into arbitration or similar agreements with your patients?	Yes _____	No _____
(If yes, please submit copies and describe circumstances in which they are used.)		

If you have answered yes to any of the above "Additional Professional Information" please explain:

_____
_____
_____
_____
_____

Coverage

PLEASE ATTACH A COPY OF YOUR CURRENT POLICY'S DECLARATIONS PAGE

The Exchange will provide the applicant with limits of $1 million per claim and per policy. If the insured requires higher limits to comply with the minimum required by a hospital, please identify the hospital and the limits required:

_____

The Exchange will issue claims-made insurance, which will accept claims occurring after the inception of the policy (a "first year" claims-made policy.) A "first year" claims-made policy will provide continuous coverage with no gaps if the insured's current policy is written on an occurrence basis. If the insured has been insured on a claims-made basis and does not have automatic extended reporting coverage or does not purchase an extended reporting endorsements the insured will need to purchase prior acts coverage from Exchange to avoid a gap in coverage.

If you are requesting prior acts coverage from a prior carrier, please complete the following:

Indicate the date of retroactive coverage required (your current policy's retroactive date) _____

With respect to all losses subsequent to the retroactive date:

(a) Do you know of any claims or suits that have not been reported to your prior or current insurer or other indemnitor (any source from which a claim against you would be made)?

(b) Do you know of any situation, facts or circumstances arising out of medical professional services that you rendered or should have rendered to any patient that may lead to a claim. Such circumstances could include:

- A patient or family member directly accused you of malpractice
- A patient or family member alleged care was ineffective or counterproductive
- A patient suddenly discontinued as your patient
- A patient refuses to satisfy your bills
- A patient questioned you critically about their care that was provided by colleagues alleging malpractice on their part
- A patient exhibits highly abnormal self-abusive behaviors with drugs, alcohol, etc.
- A patient refuses to follow your medical advice
- A patient seeks care from an unduly large number of physicians

Please describe:

_____
_____
_____
_____
_____
_____
_____

(c) Has a patient or attorney asked you for their medical records for any other than customary purposes? (*i.e.,* use by a referred physician, workers compensation claims, auto claims, employment needs, disability claims).

Please describe:

_____
_____
_____
_____
_____
_____

(d) Have any of your patients sustained an unexpectedly bad outcome since the retroactive date? These include, but are not limited to:

i. Retardation, cerebral palsy, seizure disorder, erb's palsy, blindness, RCF, hearing loss or cerebral hemorrhage in newborns

ii. Vascular injuries, fistula, lacerations, perforation of organs, wrong site surgery, internal bleeding or dehiscence of sutured sties in wounds, non-union of fractures in surgical patients

iii. Anaphylactic shock, colitis, pulmonary embolism, DIC, severe drug reactions, etc. in all other patients

Please describe:

_____
_____
_____
_____
_____

(e) Have any tests such as mammograms and ultrasounds blood or pathology studies, which were initially reported as negative for any of your patients been re-read as positive for cancer, traumatic injury or other serious disease after a significant amount of time has passed?

Please describe:

_____
_____
_____
_____
_____

Claims Information

Has any claim or suit for alleged medical malpractice been brought against you? Yes _____ No _____
If you have had a claim or suit, please complete a claims supplement for each claim.

Affirmation

I hereby declare and represent that the above statements and particulars are true and complete, and that I have not withheld or misstated any information required by the Exchange. I understand and agree that the information contained in the Application is material and that the Exchange is relying upon it in considering my application for professional liability insurance, and that it is the basis of insurance, which may be issued to me be the Exchange. I also understand that this Application shall be annexed to, and deemed part of, any policy of insurance issued to me by the Exchange. Renewal applications will be considered as a supplement to the original application, and all prior renewal applications, which, cumulatively, shall be deemed part of the policy.

The undersigned applicant, in the event s/he is accepted as and satisfies all conditions to become a subscriber to the Exchange, appoints as attorney of the undersigned, AHPIA Solutions, Inc., Attorney-Fact to the Exchange ("Solutions"), to vote as proxy on behalf of the undersigned as if the undersigned were personally present at any meeting of the Exchange's subscribers, or at any adjournment or adjournments thereof, in all votes in which the undersigned is eligible to participate as a subscriber relating to the Exchange's affairs, for as long as the undersigned is a subscriber to the Exchange, with Solutions to cast such votes at its sole discretion.

New York applicants, please be advised that New York Insurance Department Regulation No. 95 Declares: "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 material fact thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Signed: _____

Name: _____
Print

Date: _____