

AIG LEXINGTON INSURANCE COMPANY
ADMINISTRATIVE OFFICE: 100 Summer Street, Boston, MA 02110
(Each of the above being a capital stock company)

PODIATRIC PHYSICIAN PROFESSIONAL LIABILITY

APPLICATION

NOTICE: THIS IS A CLAIMS-MADE FORM: EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED WHILE THE POLICY IS IN FORCE OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. HOWEVER, IF A CLAIM SHOULD BE REPORTED DURING A SUBSEQUENT RENEWAL, THE CLAIM WOULD APPLY TO THE TERMS AND CONDITIONS OF THE RENEWAL POLICY. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

All questions must be answered completely. If the answer to any question is NONE or NOT APPLICABLE, so state. The application and all supplemental forms must be signed and dated by the applicant. If you requested prior acts coverage, proof of continuous claims-made coverage must be submitted with the application (the declaration page is adequate).

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS APPLICATION, AND NEXT TO EACH ITEM BELOW, PLACE AN "X" IF INCLUDED, OR "N/A" IF NOT APPLICABLE:

- _____ Continuing Education Course Certifications
- _____ Declaration Page From Your Current Policy (If Prior Acts Coverage Requested)

I. GENERAL INFORMATION

1. Name of Podiatric Physician: _____
2. Name of Professional Corporation, Partnership, Association: (Attach a copy of the letterhead)

3. Office Address: _____ Home Address: _____

Business Phone: _____
4. List offices where you are practicing: _____

5. FAX No.: _____ 6. E-mail Address: _____
7. Date of Birth: _____
8. List names of podiatrist associations in which you are an active member: _____
9. Are you currently in active, full time practice (40 hours or more a week)? Yes No
If "no", please describe fill out the Supplemental Part Time Application.

II A. COVERAGE REQUESTED

- A.1. Proposed Effective Date: _____
- A.2. Requested Limits of Liability:
 \$100,000 each incident / \$300,000 annual aggregate

- \$200,000 each incident / \$600,000 annual aggregate
- \$250,000 each incident / \$750,000 annual aggregate
- \$400,000 each incident / \$1,200,000 annual aggregate
- \$500,000 each incident / \$1,500,000 annual aggregate (Available only for Pennsylvania Insureds)
- \$1,000,000 each incident / \$1,000,000 annual aggregate
- \$1,000,000 each incident / \$3,000,000 annual aggregate
- \$2,000,000 each incident / \$6,000,000 annual aggregate

Higher Limits of Liability are available. Please contact AIG Podiatric Physician Insurance Program at 1-800-365-0816 for more information.

II B. OPTIONAL COVERAGE -- ADMINISTRATIVE HEARING COVERAGE

- B.1.** An optional Limit of Liability of \$5,000 for Administrative Hearing Coverage is available. Yes No
Is coverage requested?
- B.2.** Have you ever been involved in any administrative hearings, had any licensing board or professional ethics bodies ever require you to surrender your license or found you guilty of violations of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? Yes No
- If "yes", please provide complete detail(s). Attach a separate sheet of paper if necessary.
-

II C. COVERAGE QUESTIONS

C.1. Professional liability insurance history (all years to present):

PRIMARY	Policy Period	Insurer	Premium	Limits	CM (w/ Retro) Or Occurrence
<input type="checkbox"/> PL					
<input type="checkbox"/> PL					
<input type="checkbox"/> PL					
<input type="checkbox"/> PL					
<input type="checkbox"/> PL					

C.2. Prior Acts coverage will provide continuous coverage from the Retroactive Date on your previous Claims Made policy. Do you need this coverage? Yes No
If "yes," please attach a copy of the Declarations page from your previous carrier.
What is your proposed Retroactive Date? (/ /)

C.3. Are you a (n)?
 Sole Practitioner Employed podiatric physician without ownership interest in employer
 Preceptee Podiatric physician with ownership interest in legal Corporation, Partnership or Professional Association?
 Resident
 Full Corporate, Partnership or Association name: _____

List other podiatric physicians with ownership interest in this entity: _____

C.4. If you have ownership interest in a legal Corporation, Partnership or Professional Association, choose one option below.
Note: All podiatric physicians in the group must carry the same limits of liability and agree to the same option.
 Do not add this entity to my policy.
 Add this entity to my policy, with a single set of limits of liability.
 Add an additional set of limits of liability to my policy for this entity for an additional premium.

- C.5. Are you currently a resident? Yes No
 If "yes", what year? First Year Second Year Third Year
- C.6. Are you a first-year practicing podiatric physician? Yes No
- C.7. Have you had any Residency/ Preceptor training? Yes No
 If "yes", complete the following:
- | Director or Program Name | Start Date | Completion Date | Number of Years |
|--------------------------|------------|-----------------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

III. UNDERWRITING PROFILE

1. Has your professional liability insurance ever been canceled, declined, non-renewed, accepted only on special terms or have you ever practiced without malpractice insurance? Yes No
NOTE: MISSOURI APPLICANTS DO NOT RESPOND
 If "yes", provide details: _____
2. Has your podiatric license ever been suspended, revoked, voluntarily surrendered, or subject to probation in any state? Yes No
 If "yes", provide details: _____
3. Do you consult, teach or train outside your practice? Yes No
 If "yes", provide details: _____
4. Have you ever been accused or engaged in behavior defined as sexual misconduct with any of your current or former patients or any current or former patients' spouse or any person with a direct relationship to the patient or former patient (for example a guardian, a blood relative of the patient or spouse or any person sharing the patient's domicile)? Yes No
 If "yes", please provide details: _____
5. Current podiatric physician's license information (all licenses):
- | State | License Number | Date Licensed | Expiration Date | Practice Time (hours per week) |
|-------|----------------|---------------|-----------------|--------------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
6. a. Your narcotics license number: _____
 b. Your D.E.A. license number: _____
 c. Has your narcotics or D.E.A. license ever been subject to probation, revoked, or suspended? Yes No
If "yes", please attach an explanation and a copy of your current license.
7. Have you ever:
- a. Been convicted for violation of any law or ordinance other than minor traffic offenses? Yes No
 - b. Been treated for alcoholism or drug addiction? Yes No
 - c. Had any chronic illness or physical defect that affected your ability to practice podiatry? Yes No
 - e. Had practicing privileges with an HMO, PPO, or other managed care facility, or hospital been suspended or revoked? Yes No
- If you answered "yes" to any of the above questions, please explain on a separate sheet.**

IV. PRACTICE PROFILE

1. What percentage of your practice involves:
 _____% Sports medicine/Children _____% Diabetic patients
 _____% Other (list) _____
2. Are you involved in the practice of medicine in any other capacity? Yes No
 If "yes", please provide details: _____

3. a. Estimate amount of time spent practicing in the following locations:
- | | | | | | | | |
|------------------------|--------|---|----------|---|-----------------|---|------------|
| | Office | + | Hospital | + | Other Facility* | | |
| Percentage of time (%) | _____ | | _____ | | _____ | = | 100% _____ |
- b. List the average number of procedures you perform monthly as the primary podiatric physician at the following locations:
- | | | | | | | | |
|----------------|--------|---|----------|---|-----------------|---|-------------|
| | Office | + | Hospital | + | Other Facility* | | |
| # Soft tissue | _____ | | _____ | | _____ | = | Total _____ |
| # Bone surgery | _____ | | _____ | | _____ | = | Total _____ |
- * Please describe other facility: _____

4. List hospitals where you have privileges (list by name of hospital, city and state): Accredited by Quality Accreditation Body?
- | | | |
|--|------------------------------|-----------------------------|
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

5. List any HMO or PPO memberships: _____

6. Please list any other podiatric physicians you assist, practice in conjunction with, or are in any other way associated with, and explain your relationship:
- | Name | Relationship |
|------|--------------|
| | |
| | |

7. Estimate the number of times you perform the following procedures:
- | | |
|--|-------------------------------------|
| _____ Nail-related procedures | _____ Osseous surgery |
| _____ Abscess incision and draining | _____ Laser surgery |
| _____ Tendon/Tendon Transfer Surgery | _____ Ankle/Joint/Lower Leg Surgery |
| _____ Excision of molluscum contagiosm, cysts and other benign lesions | _____ Surgery on Achilles |
| _____ Bunion Surgery – Non-Osteotomy | _____ Minimal incision foot surgery |
| _____ Implants/Prosthesis | _____ Bunion Surgery – Osteotomy |
| _____ Other | _____ Endoscopic Plantar Fasiotomy |

8. Indicate the number of support personnel employed or contracted by you or your group:
- | | |
|----------------------------|---|
| _____ Podiatric Assistants | _____ Other Licensed Podiatric Physicians** |
| _____ CRNA** | _____ Other |

****NOTE: Coverage is not provided for CRNA or other licensed podiatric physicians.**

V. CLAIMS HISTORY

1. Has any professional liability claim or suit ever been made or brought against you, your predecessors in business, any of your employees, any member, stockholder or partner of your professional association, professional corporation, past or present partners?
If "yes", please provide details on the claim supplement form attached. Use separate form for each claim. Yes No

2. Are there any circumstances of which you are aware that may result in any professional liability claim or suit being made against you, your predecessors in business or against any past or present partner(s)? Yes No
If "yes", please provide details on a separate sheet. Please use one sheet for each incident.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Principal's Signature: _____

Title: _____

Date: _____

Name of Agent: _____

Submitted by: _____

Date: _____

Address: _____

Telephone Number: _____

Florida License #: _____