Allied Healthcare Provider
Professional Liability Insurance Application (New)

SECTION I - INSTRUCTIONS

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE. The completion and/or submission of this Application, with or without the payment of premium, does not bind Keystone Mutual Insurance Company (the "Company") to issue insurance to you. Insurance coverage is subject to the Company's receipt of this completed, signed and dated Application and the required premium due, and is also subject to underwriting approval by the Company. Insurance coverage will not be issued until each of these occur. A minimum of 30 days is generally required to process an application once it is received by the Company. The failure to provide complete information or necessary attachments may cause a delay in the processing of your Application.

Please note the following instructions:

- You must *personally* complete this Application. If you have questions as to the completion of this Application, please call the Company at 866/212-2424.
- All questions must be answered, and any required attachments or additional information must be submitted. If any question is inapplicable to you, please write "N/A" in the space provided.
- All answers must be based on your knowledge, which includes any information known or available to you, your corporate entity, your employees, partners and representatives.
- If an explanation is required for any answer, please use the forms provided in Section X – Supplemental Information Form, and Section XI – Supplemental Claim/Suit Information Form, as instructed in this Application. Those Forms may be duplicated and submitted with your Application as necessary.
- Additional instructions and information may be provided, or explanations or documentation requested, throughout this Application. Any such material is shown in *italics*.
- If you knowingly present false or fraudulent information in connection with the completion of this Application, you may be guilty of a crime and subject to fines and/or prison. If there is any question as to whether a matter should be disclosed or listed (particularly as to past incidents, claims and suits), you should include the matter.

Please include (and check the boxes below as to) each of the following with your submission to the Company:

- ☐ This Application, signed and dated
- ☐ Section X of this Application – Supplemental Information Form (if necessary)
- ☐ Section XI of this Application – Supplemental Claim/Suit Information Form (if necessary)
- ☐ The attached Authorization to Release and Disclose Information, signed and dated
- ☐ All additional documentation (i.e. agreements, CE certificates, etc.) that is requested by this Application
- ☐ A copy of your Missouri license (if applicable)
- ☐ A copy of your degree(s)
- ☐ A current *curriculum vitae* (CV)
- ☐ The Declarations page from your current professional liability policy

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SECTION II - GENERAL INFORMATION

Name of Applicant (First, Middle, Last)	**Degree**

List all other names by which you have been known, and the dates of usage for each:

Date of Birth (M/D/Y)	☐ **Male** ☐ **Female**	**Social Security Number**

Primary Office Information

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

Phone #:_____ Fax #:_____

Email Address:_____ Percentage of Practice* _____%

Secondary Office Information

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

Phone #:_____ Fax #:_____ Percentage of Practice* _____%

Home and Personal Information

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

Phone #:_____ Mobile #:_____

Preferred Method of Contact ***(Check the preferred method, and provide the information requested.)***

☐ Phone:_____ ☐ Fax:_____

☐ Email:_____

SECTION III - COVERAGE INFORMATION

Insurance History

List all previous professional liability insurers, dating back to completion of formal training, beginning with current insurer first:

_____ ☐ Claims Made From (M/D/Y):_____ To (M/D/Y)_____
(Name of Carrier) ☐ Occurrence Retroactive Date (Claims Made Only) (M/D/Y):_____

_____ ☐ Claims Made From (M/D/Y):_____ To (M/D/Y)_____
(Name of Carrier) ☐ Occurrence Retroactive Date (Claims Made Only) (M/D/Y):_____

_____ ☐ Claims Made From (M/D/Y):_____ To (M/D/Y)_____
(Name of Carrier) ☐ Occurrence Retroactive Date (Claims Made Only) (M/D/Y):_____

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_____ ☐ Claims Made From (M/D/Y):_____ To (M/D/Y)_____
(Name of Carrier) ☐ Occurrence Retroactive Date (Claims Made Only) (M/D/Y):_____

_____ ☐ Claims Made From (M/D/Y):_____ To (M/D/Y)_____
(Name of Carrier) ☐ Occurrence Retroactive Date (Claims Made Only) (M/D/Y):_____

Please explain any gaps in coverage:_____

Coverage Selection

Requested Date of Coverage (M/D/Y): _____ at 12:01 a.m.

Requested Retroactive Date (applicable only if your current policy is a claims made policy) (M/D/Y): _____

Indicate the type of coverage desired below. Prior acts coverage is available only if your current policy is a claims made policy, and covers your exposure for any claims that would be covered under that policy (i.e. with prior acts coverage, it is not necessary to purchase "tail" or extended reporting endorsement coverage under your existing claims made policy). Prior acts coverage is available only if there have been no gaps in your prior claims made coverage and after you have satisfied all of our underwriting requirements. Accordingly, you should keep your existing policy in force until we issue a policy to you.

☐ Separate Limits of Liability ☐ Shared Limits of Liability with: _____

If you have selected Separate Limits of Liability, please choose one of the following:

☐ Claims Made Coverage with Prior Acts Coverage

☐ Claims Made Coverage without Prior Acts Coverage

If you have selected claims made coverage without prior acts coverage, please indicate which one statement below applies:

☐ My prior coverage is under an occurrence policy

☐ I have purchased an extended reporting endorsement ("tail" coverage) under my prior claims made coverage

☐ I have not purchased an extended reporting endorsement ("tail" coverage) under my prior claims made coverage. I realize that my failure to purchase such coverage will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured under my prior claims made coverage.

Indicate the desired limits of liability:

☐ $100,000 each medical incident/$300,000 annual aggregate ☐ $500,000 each medical incident/$1,500,000 annual aggregate

☐ $200,000 each medical incident/$600,000 annual aggregate ☐ $1,000,000 each medical incident/$1,000,000 annual aggregate

☐ $500,000 each medical incident/$1,000,000 annual aggregate ☐ $1,000,000 each medical incident/$3,000,000 annual aggregate

Indicate the desired prior acts limits of liability (if applicable):

☐ $100,000 each medical incident/$300,000 annual aggregate ☐ $500,000 each medical incident/$1,500,000 annual aggregate

☐ $200,000 each medical incident/$600,000 annual aggregate ☐ $1,000,000 each medical incident/$1,000,000 annual aggregate

☐ $500,000 each medical incident/$1,000,000 annual aggregate ☐ $1,000,000 each medical incident/$3,000,000 annual aggregate

Indicate the desired Self-Insured Retention (choose both type and amount):

☐ Expense ☐ Indemnity ☐ Expense & Indemnity

☐ None ☐ $5,000 ☐ $10,000

☐ $20,000 ☐ $30,000 ☐ $50,000

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SECTION IV - EDUCATIONAL BACKGROUND

Undergraduate

Name of college or university:_____

City/State:_____

Dates Attended (M/Y):_____ to _____ Degree received:_____

Graduate School

Name of School:_____

City/State:_____

Dates Attended (M/Y):_____ to _____ Degree received:_____

If you are a foreign professional school graduate, are you certified by the Education Council for Foreign Medical School Graduates (ECFMG)?

☐ Yes ☐ No *If no, please explain:*_____

*If yes, please identify country, license number and date of issue:*_____

Residency

Name of Hospital/Facility:_____

City/State:_____ Specialty:_____

Dates Attended (M/Y):_____ to _____ Program Completed? ☐ Yes ☐ No

*If no, please explain:*_____

Additional Training (i.e. Fellowships, Military Service):

Name of Hospital/Facility:_____

City/State:_____ Specialty:_____

Dates Attended (M/Y):_____ to _____ Program Completed? ☐ Yes ☐ No

*If no, please explain:*_____

Additional or Specialty Training Education

Name of School:_____

City/State:_____

Dates Attended (M/Y):_____ to _____ Degree received:_____

Have you participated in continuing medical education (CME) within the last three years? ☐ Yes ☐ No

If yes, include your most recent certificate of completion with your Application submission.

If yes, how many Category 1 credit hours were obtained? _____

Have you participated in a risk management education course within the past year? ☐ Yes ☐ No

If yes, who sponsored the program?_____

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SECTION V – PRACTICE INFORMATION

Identify All States in which You are Licensed to Practice

Name of State	License #	Active	Inactive	Temporary	Pending
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

DEA License

Number:_____ From:_____ to _____

Identify All Hospitals for which You Hold Active Staff or Courtesy Privileges:

1. Name of Hospital:_____

   Address:_____
   (Number and Street) (City) (State) (Zip Code) (County)

   Type of privilege:_____ Percentage of Time per Week:_____%

2. Name of Hospital:_____

   Address:_____
   (Number and Street) (City) (State) (Zip Code) (County)

   Type of privilege:_____ Percentage of Time per Week:_____%

3. Name of Hospital:_____

   Address:_____
   (Number and Street) (City) (State) (Zip Code) (County)

   Type of privilege:_____ Percentage of Time per Week:_____%

If you do not have admitting privileges at any hospital, please describe your procedure for handling patients who require in-patient care in Section X – Supplemental Information Form, of this Policy.

Prior Practice Locations

List all locations (names and addresses) where you have practiced since residency:

Name:_____

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

Name:_____

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

Name:_____

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

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Name:_____

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

Name:_____

Address:_____
(Number and Street) (City) (State) (Zip Code) (County)

Board Certification

Are you board certified from a certifying board recognized by the American Board of Medical Specialists, the American Osteopathic Association, or the American Dental Association?

☐ Yes ☐ No If yes, please identify:

Name of specialty board:_____

Name of subspecialty board:_____

Date you received board certification (M/D/Y):_____

If you are not board certified, are you board eligible? ☐ Yes ☐ No *If no, please explain:*_____

If yes, on what date will you become board certified in your specialty? _____ subspecialty?_____

Do you hold the foreign equivalent of American board certification? ☐ Yes ☐ No

*If yes, please explain:*_____

Allied Healthcare Providers

Do you employ or provide supervision to any of the following: anesthesiologist assistants, chiropractors, cytotechnologists, emergency medical technicians, heart/lung perfusionists, inhalation therapists, interns, nurse anesthetists, nurse midwifes or technicians, nurse practitioners, optometrists, paramedics, physicians assistants, podiatrists, psychologists, residents, scrub nurses, surgical assistants, or any other person licensed, certified or otherwise authorized to provide advanced health care services in the absence of direct supervision by a licensed physician? ☐ Yes ☐ No

If yes, please provide the following information for each such provider:

Name	Specialty	Employee	Supervise Only
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

If insurance coverage for you is approved, it will not extend to any other allied healthcare providers. Allied healthcare providers may apply for coverage by completing and submitting an application for a separate policy to the Company.

Professional Associations

List all professional associations to which you belong:

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SECTION VI – BUSINESS ENTITY INFORMATION

Name of Business Entity

Type of Business Entity

☐ Sole Proprietor/Solo Unincorporated ☐ Solo Incorporated – No employed or contracted physicians

☐ Multi-shareholder Corporation, Partnership, Association or Limited Liability Company

☐ Other – Please explain:_____

Employment Status

☐ Sole Proprietor ☐ Employee ☐ Shareholder/Partner/Member ☐ Independent Contractor ☐ Other

*If other, please explain:*_____

Other Practitioners and Office Procedures

Name of other allied providers associated with your business entity:	Their present professional liability insurer:	Policy #:	Expiration Date:

Do you share employees with these providers? ☐ Yes ☐ No

Do you share calls with these providers? ☐ Yes ☐ No

Do you share calls with other providers? ☐ Yes ☐ No

If yes, how many other providers with whom you share calls? _____

Coverage Information

Is this business entity currently insured with Keystone Mutual Insurance Company? ☐ Yes ☐ No

If yes, please provide the policy number:_____

You may obtain coverage for your business entity as an additional insured under your policy with this Application if you satisfy our requirements.

Do you desire coverage for this business entity? ☐ Yes ☐ No

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SECTION VII - RATING INFORMATION

Identify Specialty and Subspecialty for Which You are Requesting Coverage:

Specialty:_____ Percentage of Practice _____%

Has your specialty changed in the last five years? ☐ Yes ☐ No

If yes, please explain:_____

Patients Seen and Office Hours for the Business Entity referenced in Section VI

1. How many scheduled patients do you see per week? _____
2. How many walk-in patients do you see per week? _____
3. How many hours do you work per week? _____
4. In the past five years, has there been a change in the number of hours you work per week? ☐ Yes ☐ No
5. Are any of your patients seen only by you and not by a licensed physician, surgeon or dentist? ☐ Yes ☐ No

   If yes, how many patients per week?_____

Office Procedures and Personal History

If you answer yes to any Question below other than Questions 1 and 2, please provide all details in Section X - Supplemental Information Form of this Application.

1. Do you consistently use written informed consent in your practice? ☐ Yes ☐ No
2. Do you consistently use manufacturers' informed consent forms in addition to your own form where use of such forms is suggested by such manufacturers (i.e. as to silicone breast implants)? ☐ Yes ☐ No
3. Do you serve as a proprietor, administrator, officer, superintendent, stockholder, medical director or member of the board of directors, trustees, governors or similar governing or administrative body of any hospital, sanitarium, ambulatory care center, health maintenance organization, preferred provider organization, exclusive provider or similar organization, dialysis center, blood bank, outpatient care center, laboratory, clinic with bed and board facilities, nursing home, institution, or any other similar business enterprise? ☐ Yes ☐ No
   If yes, then: Indicate the name of the entity:_____
   Indicate the location of the entity:_____
   Does the entity provide professional liability insurance for you? ☐ Yes ☐ No
   Does the entity provide insurance for your administrative responsibilities? ☐ Yes ☐ No
   Attach a copy of any Agreement between you and the entity.
4. Have you discontinued any practice activity within the last 10 years? ☐ Yes ☐ No
   If yes, indicate: What activity did you discontinue?_____
   When did you discontinue the activity?_____
5. Do you practice in, or staff, a trauma or urgent care center, walk-in urgi-care center or similar emergency clinic? ☐ Yes ☐ No
6. Do you administer, or supervise the administration of, anesthesia in a non-hospital setting? ☐ Yes ☐ No
7. If you answered yes to Question 5 or 6, does the facility provide professional liability insurance coverage for you? ☐ Yes ☐ No
   If yes, then indicate: The carrier's name:_____
   Policy Number:_____
   Expiration Date (M/D/Y):_____
8. Do you treat patients of other practitioners, including patients that are admitted to nursing homes or care facilities by other physicians? ☐ Yes ☐ No
   If yes, how many patients per week?_____

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9. Do you currently supervise or administer any departments within a hospital or any other facility for a health maintenance organization, preferred provider organization or similar entity, or for any governmental agency or program? ☐ Yes ☐ No
(If yes, attach a copy of your Agreement with such entity, agency or program.)

10. Are you a party to any agreement involving the provision of professional healthcare services in which you have agreed to indemnify any other person or entity? ☐ Yes ☐ No
(If yes, attach a copy of the Agreement with such person or entity.)

11. Do you practice any forms of alternative medicine, including chiropractic, holistic, Chinese, naturopathic, Homeopathic or ayurvedic? ☐ Yes ☐ No

12. Do you perform any joint injections? ☐ Yes ☐ No
If yes, indicate: Where on the body?_____
How many per month?_____
For what purpose?_____

13. Are you affiliated with or employed by any state or federal governmental agency or program, including, but not limited to, the United States military or any federal or state correctional facility, etc.? ☐ Yes ☐ No

14. Do you provide any diagnostic, consulting or other professional services to patients in states other than those in which you are licensed, including, but not limited to, the use of telecommunication technology? ☐ Yes ☐ No

15. Do you participate in any quality assurance, peer review or utilization review activities for any other person, entity or agency? ☐ Yes ☐ No
If yes, what percentage of time annually do you spend on such activities?_____%

16. Do you perform any medical related legal evaluations (i.e. as an expert witness)? ☐ Yes ☐ No
If yes, indicate: For who?_____
Subject matter_____
Percentage of your practice this entails: 100 %

17. Do you have any teaching responsibilities? ☐ Yes ☐ No
If yes, indicate: Name of institution:_____
Weekly percentage of time this entails: _____%
Do you see and treat patients while teaching? ☐ Yes ☐ No
Does the institution provide insurance coverage for you? ☐ Yes ☐ No

18. Do you utilize a collection agency that has the authority to file suit without your prior approval? ☐ Yes ☐ No

19. Do you participate in pharmaceutical testing or clinical investigation studies that are not approved by the United Stated Food & Drug Administration? ☐ Yes ☐ No
(If yes, please include a copy of the indemnification agreement between you and the pharmaceutical company along with an explanation of such testing or studies.)

20. Other than as may have been already disclosed in Questions 3, 7 and 17, above, will you be performing activities that will be covered by another professional liability insurance policy? ☐ Yes ☐ No
If yes, please complete the following:
☐ Employee ☐ Independent Contractor ☐ Resident/Fellow
Practice Name and Location:_____
Name of Carrier:_____

21. Have you ever been charged with, indicted for, convicted of, or plead guilty or no contest to, any violation of any law or ordinance other than minor traffic offenses? ☐ Yes ☐ No

22. Have you ever had your hospital privileges, professional license, DEA license or Medicaid/Medicare Privileges revoked or suspended, or have you ever been subject to reprimand, placed on probation or voluntarily surrendered such privilege or license? ☐ Yes ☐ No

23. Have you ever been asked to resign or involved in any official or unofficial proceedings brought by any hospital, managed care organization or other healthcare facility that involved the denial, limitation, suspension, nonrenewal or revocation of your privileges? ☐ Yes ☐ No

24. 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 health issue? ☐ Yes ☐ No

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25. Do you currently have any condition that may impair your ability to practice, including but not limited to, any alcohol, narcotics or substance abuse addiction or condition, or mental or physical health issue? ☐ Yes ☐ No
(If yes, you must include a statement from your treating physician with your Application that describes your condition and indicates whether it could adversely affect your ability to practice medicine.)

26. Have you ever been asked to participate, or have you voluntarily participated, in any impaired physician or preceptorship program, or have you ever been under punitive or disciplinary observation? ☐ Yes ☐ No

27. Have you ever been denied board certification? ☐ Yes ☐ No

28. Have you ever been denied a professional or DEA license? ☐ Yes ☐ No

29. Have you ever had your membership in any professional society or association refused, suspended, revoked, or have you been subject to any reprimand, censure or other discipline by any such society or association? ☐ Yes ☐ No

30. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

31. Has any patient or patient's representative ever filed any complaint or grievance against you with, or have you ever been notified to appear before, any hospital committee, state licensing or regulatory agency, or other medical review committee? ☐ Yes ☐ No

32. Have you ever been investigated by, or entered into any consent agreement with, any hospital committee, state or federal licensing or regulatory agency, or other medical review committee? ☐ Yes ☐ No

33. Have you ever altered any medical record (except where a reasonable basis for the alteration existed and it was consistent with acceptable standard of practice, and such alteration was duly noted as such)? ☐ Yes ☐ No

Podiatrist Information

This Section is to be completed by podiatrists only.

1. Do you perform surgery in your office? ☐ Yes ☐ No

2. Do you perform surgery in other non-hospital facilities? ☐ Yes ☐ No
*If yes, where?*_____

3. If yes to either Question 1 or 2, do you have emergency resuscitation equipment on site? ☐ Yes ☐ No

4. Do you personally provide pre-operative examination and post-operative care to all surgical patients? ☐ Yes ☐ No
If no, please explain on Section X – Supplemental Information Form.

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Procedures Performed for Which Coverage is Requested

Please check any of the following procedures that apply to your practice, and indicate practice percentages where requested:

- ☐ **None**
- ☐ Abortions - # per year?_____
- ☐ Acupuncture
  - ☐ Therapeutic/Local Anesthesia
  - ☐ General Anesthesia
- ☐ Adenoidectomy
- ☐ Amniocentesis
- ☐ Anesthesia
  - ☐ Spinal
  - ☐ Caudal
  - ☐ General
  - ☐ Local
  - ☐ Other
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Arteriography
- ☐ Blepharopigmentation
- ☐ Blepharoplasty
  - ☐ Cosmetic: ____% of Practice
  - ☐ Reconstruction: ____% of Practice
- ☐ Botox: ____% of Practice
- ☐ Breast Implants
  - ☐ Cosmetic: ____% of Practice
  - ☐ Reconstruction: ____% of Practice
- ☐ Bronchoscopy
- ☐ Broncho-Esophagology
- ☐ Casting and Splinting
- ☐ Cataract Surgery
- ☐ Catheterization
  - ☐ Left Heart
  - ☐ Right Heart
  - ☐ Swan-Ganz
- ☐ Cesarean Sections - # per year?_____
- ☐ Chemonudeolysis
- ☐ Chelation Therapy
- ☐ Cholecystectomy
- ☐ Cholecystectomy – Laparoscopic
- ☐ Colonoscopy
- ☐ Cryosurgery (other than minor lesions)
- ☐ Dental Related Fields (incl. Hygienist)
- ☐ Dermatological Surgery
  - ☐ Chemical Peels
  - ☐ Chemobrasion
  - ☐ Dermabrasion
  - ☐ Fat Transfer
  - ☐ Hair Transplants
  - ☐ Silicone Injections
  - ☐ Tumescent Liposuction
  - ☐ Other:_____
- ☐ Dermatopathology
- ☐ D&C
- ☐ Electromagnetic Therapy
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopic (other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy)
- ☐ Epidural Steroid Injection
- ☐ ERCP
- ☐ Fluoroscopy
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Gastroscopy
- ☐ Hip Nailings
- ☐ Hyperbaric Medicine
- ☐ Hysterectomy
- ☐ Joint Injections
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ Laser Hair Removal
- ☐ Laser Skin Resurfacing
- ☐ Laser Surgery
- ☐ LASIK - # per year?_____
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Lumbar Fusion
- ☐ Lymphangiography
- ☐ Mammography
- ☐ Myelography
- ☐ Needle Biopsy
- ☐ Nerve Blocks
  - ☐ Paraspinal
  - ☐ Sciatic
  - ☐ Facet
  - ☐ Paravertebral
  - ☐ Peripheral
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Trigger point Injection
  - ☐ Intrathecal Pumps
  - ☐ Spinal Cord Stimulator
- ☐ Norplant Insertion/Extraction
- ☐ Obstetrical Delivery - # per year?____
- ☐ Organ Transplant
- ☐ Oxidation Therapy
- ☐ Pacemaker
- ☐ Pain Management
  - ☐ Interventional
  - ☐ Non-Interventional
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Peritoneoscopy
- ☐ Phlebography
- ☐ Pneumoencephalography
- ☐ Podiatry
- ☐ Polypectomy
- ☐ Prenatal Care
  - ☐ First and Second Trimester
  - ☐ To Term, but No Delivery
  - ☐ To Term and Perform Delivery
- ☐ Prolotherapy
- ☐ Radial/laser keratotomy
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye
- ☐ Rectal Ozone Therapy
- ☐ Shock Therapy
- ☐ Sigmoidoscopy
- ☐ Silicone Injections
- ☐ Skin Flaps/Grafts
  - ☐ Cosmetic: ____% of Practice
  - ☐ Reconstruction: ____% of Practice
- ☐ Spinal Injections
- ☐ Surgery, including:
  - ☐ Assist in Major Surgery
    - ☐ Own Patients
    - ☐ Patients of Others
  - ☐ Cardiac: ____% of Practice
    - ☐ Cardiovascular Disease
  - ☐ Emergency Medicine
  - ☐ First Assistant
  - ☐ Gastric Bypass/Bariatric
  - ☐ General
  - ☐ Gynecology: ____% of Practice
  - ☐ Hand: _____% of Practice
  - ☐ Head and Neck
  - ☐ Neurology: ____% of Practice
  - ☐ Obstetrics: ____% of Practice
  - ☐ Ophthalmology: ___% of Practice
  - ☐ Organ Transplant
  - ☐ Orthopedic
    - ☐ Spine: ____% of Practice
    - ☐ Other: ____% of Practice
  - ☐ Otology
  - ☐ Otorhinolaryngology:_____% of Practice
    - ☐ Elective Cosmetic Procedures
    - ☐ Non-Elective Cosmetic Procedures
  - ☐ Plastic
    - ☐ Cosmetic: _____% of Practice
    - ☐ Reconstruction: _____% of Practice
  - ☐ Podiatry
  - ☐ Professional Athletes: ____% of Practice
  - ☐ Scoliosis
  - ☐ Scrub Nurse
  - ☐ Sexual Reassignment
  - ☐ Thoracic: ____% of Practice
  - ☐ Traumatic: _____% of Practice
  - ☐ Urology: ____% of Practice
  - ☐ Vascular: ____% of Practice
  - ☐ Other:_____
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Trigeminal Lesioning
- ☐ Tubal Ligations
- ☐ Vasectomy
- ☐ Weight Control Therapy
  - ☐ Medication
  - ☐ Gastric Bubble
  - ☐ Gastric Stapling
  - ☐ Other:_____
- ☐ Other Medical Procedures (List):

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SECTION VIII - LOSS INFORMATION

A. Involvement with Claim or Suit

Are you now, or have you ever been, directly or indirectly involved in any claim, potential claim or suit arising out of the rendering or failing to render professional services? ☐ Yes ☐ No

(If yes, please complete Section XI - Supplemental Claim/Suit Information Form of this Application.)

B. Knowledge of Potential Claim or Suit

Other than any matter already disclosed under Question A, above, do you have knowledge of any incident, circumstance or potential adverse outcome that resulted, or may result, in injury or death, or in a claim, potential claim or suit involving you (even if you believe any such claim or suit to be without merit)? ☐ Yes ☐ No

(If you answer yes, please complete Section XI - Supplemental Claim/Suit Information Form of this Application.)

C. Knowledge of Specific Circumstances – All Applicants

1. Other than as already disclosed in this Application, have any of the following occurred which may reasonably result in, or be possibly related to, a claim or suit being brought against you (even if you believe any such claim or suit to be without merit)?

   Request for records by a patient and/or a patient's attorney or other representative? ☐ Yes ☐ No

   Letter or other communication from a patient or patient's attorney or other representative? ☐ Yes ☐ No

   Fee dispute with a patient? ☐ Yes ☐ No

2. Other than as already disclosed in this Application, have any of the following occurred in the last three years?

   Had a patient die while under your care that was outside of natural causes, due to an adverse event, or was unexpected? ☐ Yes ☐ No

   Expression of dissatisfaction with treatment by any patient or any party on behalf of such patient? ☐ Yes ☐ No

3. Other than as already disclosed in this Application, have there ever been any intra-operative complications or other treatment complications that may result in: death or other disability of any existing or former patient, or that may reasonably result in, or be possibly related to, a claim or suit being brought against you (even if you believe any claim or suit to be without merit)? ☐ Yes ☐ No

(If yes to any question, please provide all details in Section X - Supplemental Information Form of this Application.)

D. Knowledge of Specific Circumstances – Obstetrical Healthcare Only

1. Other than information already disclosed in this Application, participated in the delivery of a child, in the last 10 years, where:

   The child was diagnosed as having any kind of brain damage, mental retardation or neonatal or post-natal seizures? ☐ Yes ☐ No

   Anyone claimed or complained that the child had shoulder dystocia or brachial plexus injury? ☐ Yes ☐ No

   Placental abruption occurred and the mother died? ☐ Yes ☐ No

2. Have you delivered any baby in the last five years that died? ☐ Yes ☐ No

(If yes to either question, please provide all details in Section X - Supplemental Information Form of this Application.)

E. Reporting of Circumstances and Incidents

1. Are there any facts or circumstances that might reasonably lead to an incident, claim or suit, even if you believe the claim or suit may be without merit and including those identified in Items A through D, above, that have not been reported to your current or prior professional liability carrier? ☐ Yes ☐ No

2. Has any incident, claim or suit that involves or may involve you been reported to any other professional liability carrier by any other person or entity on their own behalf, but not on your behalf? ☐ Yes ☐ No

(If yes to Question 2, please provide all details in Section X - Supplemental Information Form of this Application.)

SECTION IX – REPRESENTATIONS, PARTICIPATION AGREEMENT AND REVOCABLE PROXY

I hereby declare, represent and warrant to Keystone Mutual Insurance Company (the "Company") that all of my answers, statements, descriptions and particulars set forth in this Application are true and correct, and that I have not suppressed or misstated any material fact. I agree to immediately notify the Company if there is any change in any of such answers, statements or particulars, including, without limitation, my professional specialty, affiliation or working arrangement with any other physician, firm or professional association. I further agree to be bound by, and subject to, the Company's underwriting guidelines, policies and procedures.

I affirm and represent that I have fully and completely listed all claims, suits and incidents known to me, or of which I should reasonably be aware, which may arise from my acts or omissions.

I UNDERSTAND AND AGREE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION BY ME IN THIS APPLICATION MAY RESULT IN RENDERING ANY CONTRACT OF INSURANCE ISSUED BY THE COMPANY NULL AND WITHOUT EFFECT, PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND ANY CONTRACT OF INSURANCE ISSUED PURSUANT TO THIS APPLICATION, AND/OR REQUIRE RETROACTIVE UPWARD PREMIUM ADJUSTMENT.

I UNDERSTAND THAT KNOWINGLY PRESENTING FALSE INFORMATION, OR CONCEALING INFORMATION, IN SUPPORT OF AN APPLICATION FOR ISSUANCE OR RATING OF AN INSURANCE POLICY, OR IN SUPPORT OF A CLAIM FOR PAYMENT OR OTHER BENEFIT UNDER ANY INSURANCE POLICY, IS A FELONY WHICH MAY SUBJECT ME TO FINE AND IMPRISONMENT.

I AM NOT RELYING ON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME, OR THAT A POLICY OF INSURANCE WILL BE ISSUED. I UNDERSTAND AND AGREE THAT I HAVE NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS, AS A PRECONDITION TO SUCH COVERAGE (1) RECEIVED AND REVIEWED AND APPROVED MY COMPLETED APPLICATION; (2) OFFERED ME A PREMIUM QUOTE; AND (3) RECEIVED THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND AND AGREE THAT NO PREMIUM OR INSTALLMENT SHALL BE DEEMED RECEIVED BY THE COMPANY UNTIL MY CHECK, MONEY ORDER OR ELECTRONIC TRANSFER HAS BEEN HONORED BY THE INSTITUTION ON WHICH IT IS DRAWN.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS, OR WITH THE TERMS OF ANY CONTRACT OF INSURANCE ISSUED BY THE COMPANY, I WILL HAVE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I understand and agree that this Application shall be the basis of my insurance contract with the Company. I understand and agree that, upon acceptance of my Application by the Company, this Application will become a part of the policy and operate as part of the contract between me and the Company.

I agree to fulfill all of the rights and obligations of the "Preferred Class" (i.e. the first 30 members of the Company) and of the "Common Class" (i.e. all remaining members of the Company, except those who may later become members of the Preferred Class in accordance with the Company's *Articles of Association*), as applicable, as defined in the Company's *Articles of Association* and including specifically, the following:

Members of the Preferred Class shall be entitled to receive noncumulative dividends from legally available funds in preference to the members of the Common Class at the rate of five percent (5%) per member, *per annum*, when, as and if declared by the Board of Directors. In the event of any dissolution or liquidation of

the Company or winding up of the Company's business, members of the Preferred Class shall be entitled to receive in preference to the members of the Common Class an amount equal to the total of their initial capital contribution, plus any declared and unpaid dividends. Members of the Preferred Class shall have no voting rights.

Subject to the preferences that may be applicable to the members of the Preferred Class, if any, members of the Common Class are entitled to receive such lawful dividends as declared by the Company's Board of Directors, and will share such dividends on a *pro rata* basis. In the event of the Company's liquidation or dissolution, or the winding up of the Company's business, and subject to the rights of the Preferred Class, members of the Common Class will be entitled to receive, *pro rata*, all of the Company's remaining assets for distribution to its members. Members of the Common Class shall each have one vote on all matters to be voted on by the Company's policyholders, which shall be irrevocably and indefinitely transferred and assigned to a member of the Common Class selected from among the Common Class by the Nominating Committee of the Board of Directors (the **"Common Class Delegate"**). In the event a Common Class Delegate becomes a member of the Preferred Class in accordance with the procedures set forth in the Company's *Articles of Association*, a successor Common Class Delegate shall be selected by the Board of Directors from among the members of the Common Class. The Common Class Delegate shall irrevocably and indefinitely transfer and assign to James R. Bowlin or his successor (the **"Transferee"**) such Common Class Delegate's right to vote on behalf of the Common Class with respect to all issues presented to the Company's policyholders for decision. At all meetings of the policyholders of the Company, and in all proceedings affecting the Company, the Transferee shall have the exclusive right to vote the votes transferred to the Transferee hereunder in such manner as the Transferee may determine in his or her discretion.

I agree to pay any regular or special assessment that may be levied by the Company in accordance with the Company's *Articles of Association*. Regular assessments may be levied on current and former Preferred Class and Common Class members of the Company monthly, quarterly, semiannually or annually without limitation as to frequency, in the manner provided by the Company's *Bylaws*, as determined by the Board of Directors. The amount of such assessment(s) shall also be as determined by the Board of Directors in its sole and absolute discretion. Special assessments may be made in like manner. Regular and special assessments may be levied upon current Preferred Class and Common Class members, and former Preferred Class and Special Class members who were members as of the year to which such assessment relates, if the such date of the assessment is encompassed by the policy year of such former member's insurance policy issued by the Company, regardless of whether such former member's policy is in effect as of the date the assessment is declared or notice thereof is provided to such former member, or both. Notwithstanding the foregoing, the maximum amount of any one regular or special assessment which the Company may levy against a member or former member shall be that member's, or former member's, *pro rata* share of the amount of any statutory net loss (i.e. statutory net income which is less than zero) occurring during any monthly, quarterly, biannual or annual period to which the assessment applies; provided, that the Company may, but shall not be obligated to, consider the loss experience of each individual member in the levying of assessments. No interest, dividends or other income shall accrue or be payable from the Company to policyholders on any assessment paid by such members, and the assessment shall be non-refundable unless otherwise determined by the Board of Directors.

I agree that, in additional consideration of the potential for return provided to me and other Company policyholders as a result of the creation and ongoing management of the Company by its Board of Directors, the ownership structure resulting from any demutualization and conversion of the Company to a stock-based insurer shall be as follows, and any and all rights in and to any additional ownership interest is hereby specifically waived. Preferred Class members of the Company who have been continuously insured by the Company for at least three years immediately preceding such demutualization and conversion, and are insured by the Company on the date of any demutualization and conversion, shall receive ten percent (10%) ownership interest. Common Class members of the Company who have been continuously insured by the Company for at least three years immediately preceding such demutualization and conversion and are insured by the Company on the date of any demutualization and conversion shall receive 27 percent (27%) ownership interest. James R. Bowlin, or his designee, shall receive 40 percent (40%) ownership interest, Scott B. Lakin, or his designee, shall receive seven percent (7%) ownership interest, the Board of

Directors of the Company other than those members and individuals listed above shall receive 15 percent (15%) ownership interest in accordance with policies of the Company, and Employees of the Company or its contractors other than those members and individuals listed above shall receive one percent (1%) ownership interest in accordance with policies of the Company.

I agree to, and do hereby, waive any and all rights to assert any cause of action against the Company, its Directors, Officers, members, employees and agents arising out of or relating to the cancellation or non-renewal of Member's insurance coverage, the suspension of Member's membership in the Company, and/or the imposition of any assessment in accordance with the Company's *Articles of Association*, including, but not limited to, any cause of action for defamation, invasion of privacy and breach of contract, and further agrees to indemnify, save, defend and hold such parties harmless from all such causes of action.

I understand that I may, upon request, obtain a complete description of the Company's organization, capitalization and operation, and that I have been provided with the opportunity to review such information and to ask any questions of the Company relative thereto.

I also understand that I can request and review a copy of the Company's *Fraud Policy* at any time.

I understand and agree that my Initial Capital Contribution and all Annual Capital Contributions paid to the Company by me or on my behalf are non-refundable.

I agree that any cancellation of my policy by me during its term will result in the Company retaining unearned premium in accordance with its policies, which the Company will provide to me at my request.

If applicable, I further understand and agree that I will not receive any amount from my Keystone Capital® member retirement savings account if I terminate or cancel my insurance coverage with the Company other than through death, disability, or retirement after age 55, and that my Keystone Capital® balance will be reduced by the amount expended by the Company for any purpose on any incident or claim presented by me to the Company.

REVOCABLE PROXY

The Annual Meeting of the members of Keystone Mutual Insurance Company will be held on Friday, June 11, 2027, at 10:00 a.m., at the Company's headquarters at 13537 Barrett Parkway Dr., Suite 345, St. Louis, Missouri 63021, for the following purposes:

1. To elect Tatyana Petrosova, MD as the Common Class Delegate to assign to the Transferee the right to vote the Common Class votes.

2. The Transferee's ratification of the election of the following Directors for a three-year term for the period 2027-30:

   James R. Bowlin
   Bruce C. Oetter
   Dr. George K. Parkins

3. The Transferee's ratification of the selection of Armanino, LLP, as the Company's auditor.

4. To authorize the Transferee to vote on such other business as may come before the meeting.

You are cordially invited to attend the meeting, and this Revocable Proxy is provided for you in the event you do not plan to attend the Annual Meeting. This proxy is solicited by the Board of Directors.

THIS REVOCABLE PROXY, WHEN PROPERLY EXECUTED, WILL BE VOTED IN THE MANNER DIRECTED HEREIN BY THE MEMBER SIGNING ABOVE.

By signing and dating this proxy, you authorize the proxy to vote **for** electing Dr. Tatyana Petrosova as the Common Class Delegate to assign to the Transferee the right to vote the Common Class Votes.

THIS PROXY MAY BE REVOKED AT ANY TIME PRIOR TO THE DATE OF THE ANNUAL MEETING THROUGH THE COMPANY'S RECEIPT OF WRITTEN REVOCATION OF THIS PROXY BY THE MEMBER SIGNING ABOVE.

THIS REVOCABLE PROXY SHALL APPLY ONLY IF YOU ARE CHARGED AND PAY A CAPITAL CONTRIBUTION TO THE COMPANY, AND COMPLY WITH ALL OTHER REQUIREMENTS TO BE A MEMBER OF THE COMPANY'S COMMON CLASS OF MEMBERSHIP.

_____
(Signature)

_____
(Print Name)

_____
(Date)

FOR AGENT'S USE ONLY

Name of Agency:_____ Name of Agent:_____

Address:_____ Phone Number:_____

Email Address:_____ Fax Number:_____

Signature:_____ Date (M/D/Y):_____

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SECTION X – SUPPLEMENTAL INFORMATION FORM

Indicate the Section and Question number in this Application to which your supplemental information applies.

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SECTION XI – SUPPLEMENTAL CLAIM/SUIT INFORMATION FORM

Complete this Section only if you answered "yes" to either Question A or B in Section VIII of this Application. This form may be photocopied and submitted with your Application to provide information about additional cases.

Your Name:_____

1. Patient Information:

   Name:_____
   (First) (Middle) (Last)

   Age:_____ Gender: ☐ Male ☐ Female

2. Date of treatment and/or surgery that led to the claim, suit or matter (M/Y):_____/_____

3. Date you received notice of the claim, suit or matter (M/Y):_____/_____

4. Date the claim was reported to prior insurer (M/Y):_____/_____

5. Names of all other doctors, hospitals and health care providers involved in the claim, suit or matter:_____

6. Current status of the claim, suit or matter: ☐ Open ☐ Closed

   If closed, the date of closure (M/Y):_____/_____

7. Indicate the status or disposition of the matter:

   ☐ Incident report only ☐ Claim threatened, no action taken ☐ Suit threatened, no action taken
   ☐ Suit filed, but dropped by claimant ☐ Summary judgment in your favor ☐ Summary judgment in claimant's favor
   ☐ Jury verdict in your favor ☐ Jury verdict in claimant's favor ☐ Suit settled out of court
   ☐ Suit filed, awaiting mediation ☐ Suit filed, awaiting court action

8. Indicate case value established by insurance carrier: $_____

9. Claim or Suit Number (if known):_____

10. Was the matter closed with your consent? ☐ Yes ☐ No

12. Was payment made? ☐ Yes ☐ No

13. If yes, the total amount of the payment: $_____,

    and the amount paid on your behalf: $_____

14. Nature of the allegations:_____

15. Condition treated:_____

16. Alleged negligence:_____

17. Alleged injury:_____

18. Did you in any way alter, embellish, delete, change and/or destroy any records, medical or otherwise, or was it alleged that you did so, in connection with this claim, suit or matter? ☐ Yes ☐ No

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19. Please provide a narrative description of all medical facts, including the type of treatment and/or surgery, the nature of your involvement, etc.):

AUTHORIZATION TO RELEASE AND DISCLOSE INFORMATION

The undersigned hereby authorizes all present and prior professional liability insurance carriers, and any and all attorneys who have represented the undersigned in connection with any incident, claim or suit involving professional liability, to release to Keystone Mutual Insurance Company (the "Company") upon its request any and all information regarding any closed, pending or anticipated incidents, claim(s) or suits, and any and all underwriting and other information requested by the Company.

The undersigned further authorizes all state and federal licensing boards or agencies, national or state medical societies of any type or nature, all hospitals in which the applicant had, or currently holds, staff privileges, and all physicians or any other individuals with information regarding the undersigned, to release to the Company upon its request any and all information regarding the undersigned.

The undersigned also agrees to release and hold all such entities, agencies and/or persons, their directors, officers, agents, employees and representatives, and the Company, its directors, officers, agents, employees and representatives, harmless from any and all liability arising out of the release or use of such information released and/or furnished pursuant to this Authorization.

The undersigned acknowledges and agrees that any such information provided to the Company pursuant to this Authorization, as well as the identities of any entity, agency and/or person providing such information, will be held by the Company on a confidential basis, and will not be disclosed to the undersigned. The undersigned hereby waives any right to compel such disclosure, and agrees not to seek to discover or compel the disclosure of any such information through any judicial process, including, but not limited to, litigation or other proceedings.

The undersigned further authorizes the Company to disclose to any such person, entity or agency contemplated by this Authorization any information about the undersigned that the Company determines to be necessary and/or appropriate, in its sole discretion, to effect its investigations and inquiries concerning, and review and consider the Application for insurance by, the undersigned.

The undersigned agrees that any photocopy of this Authorization shall be considered as an original, and may be relied upon by any third party as such.

_____
(Signature)

_____
(Print Name)

_____
(Date)