



Jane M. Benedict, ARM, WCCP

6165 Greenwich Drive, Suite 200, San Diego, CA 92122

Direct Phone: 858.869.8361

Fax: 858.869.8301

Email: jbenedict@vanorsdale.com

www.vanorsdale.com

Medical Division Manager

License #OB23506



ASBP EXCLUSIVE PREFERRED PROVIDER - BARIATRIC PHYSICIAN (RENEWAL)
(Professional Liability - Claims Made Coverage)

I. GENERAL INFORMATION

- 1. (a) Full name of Applicant:
(b) Entity Name:
(c) Principal practice address:
(d) (i) Phone: (ii) Fax:
(iii) E-Mail Address: (iv) Website Address:

III. SCOPE OF PRACTICE

- 1. Are you currently a dues paying member of the American Society of Bariatric Physicians?
2. Are you a diplomate of the American Board of Bariatric Medicine?
3. Do you subscribe to the ASBP Bariatric Practice and Anorectic usage Guidelines?
4. Percentage of your patients that are weight control patients:
5. Do you dispense any drugs to weight control patients?
6. Do you use injections for weight control?
7. (a) Average weekly patient load: (b) Number of patients annually:
8. Average number of hours you practice each week:
9. Do you supervise anyone other than your own employees?
10. Do you anticipate any changes in your practice in the next year?

V. HISTORY AND CLAIMS

Have there been any changes in the following from previous years? (Attach detailed explanation for any "yes" answers)

- 1. Hospitals and surgicenters where you are a staff member or have privileges?
2. Are you currently a hospital chief of staff or head of any hospital department?
3. Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin superficial fascia?
4. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)?

5. Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? [] Yes [] No
6. Are you a Principal Investigator for any clinical trial? [] Yes [] No
7. Changes in your professional staff? [] Yes [] No
8. Has any claim or suit for malpractice been made against you or any entity proposed for this insurance during the past year? [] Yes [] No
9. Has there been any activity on previously reported claims in the past year? [] Yes [] No
10. Have you been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? [] Yes [] No
11. Has your license to practice medicine or your permit to prescribe or dispense drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? [] Yes [] No
12. Have you been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? [] Yes [] No
13. Have you been charged with or convicted of an act committed in violation of any law or ordinance? [] Yes [] No
14. Have you been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? [] Yes [] No
15. Do you have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? [] Yes [] No

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the Company receives notice is on file with the Company and is considered physically attached to and part of the of the policy if issued. The Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Company, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the Company.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant

Title

Signature of Applicant

Date

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 insurance act, which is a crime and subjects the person to criminal and civil penalties.