

FOUR TWENTY

INSURANCE GROUP

home, or other institution where medical services are customarily rendered? ____ Yes ____ No. If yes, give details, including name, location, size and number of beds.

CURRENT PRACTICE

10. A. What is your medical or surgical specialty? _____
 B. Do you limit your practice to the above specialty? ____ Yes ____ No
 C. Do you have a sub-specialty? ____ Yes ____ No. If yes, describe: _____
-

11. Do you perform one or more of the following:
- | | YES | NO |
|--|---------|------|
| A. Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)?
If "yes", describe below. If you perform any minimal incision surgery, check here _____
_____ | A. ____ | ____ |
| B. Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel)? Describe: _____ | B. ____ | ____ |
| C. Arteriography/lymphangiography/myelography/phenmoencephalography? | C. ____ | ____ |
| D. Interventional radiology-percutaneous transluminal angioplasty or embolization? | D. ____ | ____ |
| E. Radiation therapy – deep (includes radium implants)? | E. ____ | ____ |
| F. Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces? | F. ____ | ____ |
| G. Mohs micrographic surgery? Describe: _____ | G. ____ | ____ |
| H. Acupuncture (for analgesia) or Acupuncture anesthesia? Describe: _____
_____ | H. ____ | ____ |
| I. Prenatal care and normal deliveries? If "yes",
Do you perform home deliveries? ____ Yes ____ No
Do you only perform prenatal care? ____ Yes ____ No
Do you supervise nurse midwives? ____ Yes ____ No. If "yes", indicate when you refer: ____ weeks gestation | I. ____ | ____ |
| J. Dilation and currettage? | J. ____ | ____ |
| K. Needle biopsies? Describe: _____ | K. ____ | ____ |
| L. Electroshock therapy or hypnosis? Describe: _____ | L. ____ | ____ |
| M. Radial keratotomy? Indicate where performed: ____ Hospital ____ Office
____ Surgicenter | M. ____ | ____ |
| N. Hexagonal keratotomy? Indicate where performed: ____ Hospital ____ Office
____ Surgicenter | N. ____ | ____ |

12. Do you perform any one or more of the following:
- | | | |
|---|---------|------|
| A. Surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? | A. ____ | ____ |
| B. Non-spontaneous, induced abortions?
____ 1 st trimester (Not exceeding 14 weeks gestation)
____ 2 nd trimester (indicate where performed: ____ Hospital ____ Office
____ Surgicenter) | B. ____ | ____ |
| C. Sterilization procedures? Describe: _____ | C. ____ | ____ |
| D. Cosmetic plastic surgery, cosmetic body contouring (Suction lipectomy), Implantations, injections and/or blepharopigmentation? Describe: _____
_____ | D. ____ | ____ |
| E. Spinal surgery. If you also perform chemonucleolysis, check here ____ | E. ____ | ____ |

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- | | YES | NO |
|---|----------|-------|
| A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable.) | A. _____ | _____ |
| B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? | B. _____ | _____ |
| C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction? | C. _____ | _____ |
| D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? | D. _____ | _____ |
| E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? | E. _____ | _____ |
| F. Ever failed any medical licensing or specialty organization examination? | F. _____ | _____ |
| G. Do you have any chronic physician illness or defect? | G. _____ | _____ |

21. Do you supervise any individuals other than your own employees? _____ Yes _____ No.
 If "yes", provide detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-Ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

22. Are you in the employ of any individual, firm or corporation other than your own? _____ Yes _____ No. If "yes", attach explanation, including details of any responsibilities.
23. Are you under contract to any individual, firm or corporation other than your own? _____ Yes _____ No. If "yes", attach explanation including details of your responsibilities. If this contract contains a hold-harmless agreement copy of contract must be attached to application.
24. Are you in the employ of or under contract to any government entity? _____ Yes _____ No. If "yes", attach explanation, including details of your responsibilities.
25. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? _____ Yes _____ No. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? _____ Yes _____ No. If "yes", submit copy of ALL the advertisements.
26. A. From what medical school did you graduate? _____
 Degree: _____ Year: _____
 Location of medical school _____
(City) (State) (Country)
- B. If foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates? _____ Yes _____ No. If "yes", state year and describe: _____

- C. Residency? _____ Yes _____ No. If "yes", complete the following for each residency served:
 Location _____ From _____ To _____ Type _____
 Completed? _____ Yes _____ No
 Location _____ From _____ To _____ Type _____
 Completed? _____ Yes _____ No
- D. Additional Medical Training? _____ Yes _____ No. If "yes", complete the following:
 Location _____ From _____ To _____
 Type _____

27. Are you American Board certified? _____ Yes _____ No

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Medical Specialty _____ Date Certified ___/___/___ Recertified ___/___/___

28. Where have you practiced your profession since completion of training:
 In _____ From _____ To _____
 In _____ From _____ To _____
 In _____ From _____ To _____
29. Indicate membership in professional societies: _____

30. Have you participated in any continuing medical educational program within the past five years?
 ____ Yes ____ No. If "yes", describe separately.
31. Do you or the firm named in Question 6.B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? ____ Yes ____ No. If "yes", attach detailed explanation.
32. A. Has any claim or suit for alleged malpractice been brought against you? ____ Yes ____ No. If "yes", complete Supplemental Claim Information form, ADM101.
 B. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? ____ Yes ____ No. If "yes", complete Supplemental Claim Information form, ADM101.
 C. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim, or suit being made or brought against you? ____ Yes ____ No. If "yes", complete Supplemental Claim Information form, ADM101.
33. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hr. walk-in clinic or birthing center? ____ Yes ____ No. If "yes", state location and describe _____

34. A. Average patient load: ____ Patients Weekly ____ Total Patients Annually
 B. Average number of hours practice time: ____ Hours weekly
35. Do you anticipate changes in your practice in the next 12 months? ____ Yes ____ No. If "yes", explain _____

36. Approximate gross annual income from the practice (check one):
 ____ Less than \$50,000. ____ \$100,000 - \$149,999 ____ \$200,000 or more (please estimate)
 ____ \$50,000 - \$99,999 ____ \$150,000 - 199,999

37. List prior professional liability insurance carried to each of the past five years. If NONE, check here ____.

INSURANCE COMPANY	LIMITS OF LIABILITY	PREMIUM	INCEPTION MO/DAY/YR	EXPIRATION MO/DAY/YR	RETROACTIVE MO/DAY/YR	WAS THIS A CLAIMS MADE POLICY FORM?
						<u>YES</u> <u>NO</u>
1. _____						_____
2. _____						_____
3. _____						_____

ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR MOST RECENT COVERAGE.

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

 Date Signature of Applicant Title



Medical Malpractice Insurance for Physicians Recommending Medical Marijuana

All questions must be completed in full. If space is insufficient to answer any questions please attach a separate sheet. If you have any questions or concerns please call 800.420.5757. **Once complete please fax to 800.420.1975 or app@420ins.com.**

1. Full Name of Applicant: _____
2. Email Address: _____
3. Who is your primary Medical Malpractice Carrier? _____
4. Will you be performing activities which will be covered by another medical malpractice insurance policy?
 - a. If yes, are you an ___ Employee ___ Independent Contractor ___ Faculty ___ Other
 - b. Practice Name: _____
 - c. Address: _____
 - d. Name of Insurance Carrier: _____
5. Requested Effective Date (mm/dd/yyyy): ____/____/____
6. Requested Retroactive Date (mm/dd/yyyy): ____/____/____
7. What year did you start recommending Medical Marijuana? _____
8. Do you advertise your practice? [] Yes [] No
 - a. If Yes, where: _____
9. Estimated Recommendations:
 - a. Per Week: _____
 - b. Per Month: _____

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10. What is the average fee charged per recommendation: \$ _____

11. Do you perform physicals on each patient before recommendation of medical Marijuana? [] Yes [] No

12. Does the applicant:

a. Maintain documentation of the medical condition for which the patient is seeking the use of cannabis? [] Yes [] No

b. Discuss the long term risks and side effects related to the use of cannabis including but not limited to:

i. Cancer, bronchitis, severe inflammation of the airway [] Yes [] No

ii. respiratory, heart or circulatory conditions [] Yes [] No

iii. Addiction and high potential for abuse [] Yes [] No

iv. mental health problems such as increased anxiety panic attacks, depression [] Yes [] No

v. reproductive problems such as decreased sperm count and activity while interfering with ovulation and prenatal development. [] Yes [] No

13. Have you participated in any Risk Management Courses for Medical Marijuana in the last 12 months? [] Yes [] No

a. If No are you willing to take a Risk Management Course? [] Yes [] No

14. Do you make recommendations in regard to dosage? [] Yes [] No

a. If yes, explain _____

15. Do you or your staff make recommendations as to where a patient may obtain cannabis? [] Yes [] No

a. If yes, explain _____

16. Do you use a 24/7 on-line verification system for Patient Approval? [] Yes [] No

a. If No, how do you provide verification to Collectives/Cooperative's

b. If Yes, which system do you use? _____