EMERGENCY MEDICAL DIRECTOR

SUPPLEMENTAL APPLICATION

MEDICAL DIRECTOR CONTRACTS: NAME EACH ENTITY	TYPE OF ENTITY: P=PUBLIC V=PRIVATE	CITIES / COUNTIES SERVED	POPULATION OF AREA SERVED	# OF EMTS / PARAMEDICS	# EMERGENCY CALLS / # NONEMERGENCY CALLS (ANNUALLY)	REVENUE / SALARY FOR EACH CONTRACT	E=EMPLOYEE IC=INDEPENDENT CONTRACTOR
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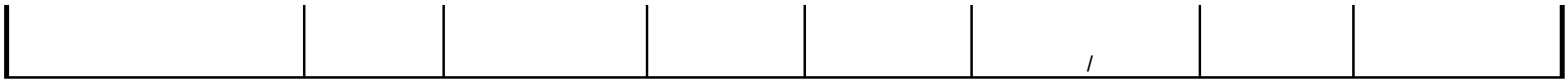

Thomas James Agency
6200 Coors Blvd. NW #K-3
Albuquerque NM 87120

APPLICATION FOR EMERGENCY MEDICAL SERVICES MEDICAL DIRECTORS PROFESSIONAL LIABILITY

THE COVERAGE IS ON A CLAIMS MADE AND REPORTED BASIS.
PLEASE READ THE COVERAGE CAREFULLY.

If you have a Curriculum Vitae (C.V.), please attach to application and check here ❑

(PLEASE TYPE OR PRINT IN INK)

1. Applicant's Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone: _____ _____ Fax: _____

2. Social Security Number _____
3. Date of Birth _____
4. Applicant is: ❑ Individual ❑ Corporation ❑ Professional Association ❑ Other _____
5. Is the applicant a licensed physician in Good Standing? ..... ❑ Yes ❑ No
6. Is the applicant a Board Certified Physician in Good Standing? ..... ❑ Yes ❑ No
7. If "Yes" to question 5. or 6., list the states where the applicant is certified and the license number:
   (Use and additional sheet of paper if necessary)

STATE OF LICENSING	LICENSE NUMBER

8. Is the applicant Certified as an EMS Medical Director? ..... ❑ Yes ❑ No
   If "Yes" list the states where the applicant is certified: _____
9. Date you were first certified as an EMS Medical Director _____
10. Are you a State EMS Medical Directior? ❑ Yes ❑ No
    If "Yes" please submit a copy of your EMS Medical Director contract/job description.

11. What is the applicant's Professional Experience and Education in the Emergency Medical Services Field? _____
    _____
    _____
    _____
12. List all other duties the applicant performs as a Physician outside of the duties as an EMS Medical Director: _____
    _____
    _____
    _____

13. a. Are you employed by or under contract to an: Hospital Emergency Department ❑ Yes ❑ No
    Urgent Care Facility ❑ Yes ❑ No

    b. If "Yes" are you insured for this practice? ❑ Yes ❑ No
    Name of insurance carrier_____

c. Do any of the entities you are a Medical Director for transport to the same Emergency Department/Urgent Care Facility your are employee/contracted to? ❑ Yes ❑ No

If "Yes"
explain:_____
_____
_____

13. Do you have a faculty appointment ❑ Yes ❑ No
If "Yes" where._____
Who provides insurance coverage for this activity and who is the insurance carrier?_____
_____

14. What Medical Director Services do you want coverage for under this policy?
_____
_____

CLAIMS HISTORY

15. a. Have there been any professional liability and/or Employment Practices Liability claims or incidents made against you, the applicant or anyone proposed for this insurance, in the last five years?..... ❑ Yes ❑ No
If "Yes", how many? _____ If "Yes", please complete a Claim/Circumstance Supplement for each claim.

b. Are you or anyone proposed for this insurance aware of any facts or circumstances which might give rise to a professional liability and/or Employment Practices Liability claim or complaint? ..... ❑ Yes ❑ No
If "Yes", how many? _____ If "Yes", please complete a Claim/Circumstance Supplement for each incident.

c. Are you or anyone proposed for this insurance aware of any charges, inquiries, investigations, grievances or other administrative or disciplinary hearings in the last five years or currently?..... ❑ Yes ❑ No
If "Yes", how many? _____If "Yes" to any, please complete a Claim/Circumstance Supplement for each.

d. Was prior Professional Liability coverage ever canceled or nonrenewed (Other than being nonrenewed due to the carrier no longer writing these coverages) (**NOT APPLICABLE TO MISSOURI APPLICANTS**)?..... ❑ Yes ❑ No
If "Yes", please explain the reason for the nonrenewal or cancellation: _____
_____

16. Limits of Liability desired for Professional Liability:
❑ $500,000/$500,000 ❑ $1,000,000/$1,000,000 ❑ $1,000,000/$2,000,000 ❑ $1,000,000/$3,000,000
Deductible desired:
❑ $0 ❑ $500 ❑ $1,000 ❑ $5,000 ❑ $10,000 ❑ Other: _____
MAXIMUM AND MINIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

INSURANCE AND CLAIM INFORMATION

17. **Do you currently carry the following:**
a. **Professional Liability Insurance as an EMT Medical Director?** ..... ❑ Yes ❑ No
List the Professional Liability Insurance carried for each of the past five years including periods of no coverage.

Policy Period From: MM/DD/YY	**To: MM/DD/YY**	**Insurance Company**	**Limit of Liability**	**Deductible**	**Claims Made or Occurrence?**	**Premium**
/ /	/ /					
addfr3 / /	/ /					
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If coverage is on a Claims Made ba sis, what is the retroactive date/prior acts date on your current policy?___

b. Physicians Medical Malpractice Professional Liability Insurance? ..... ❑ Yes ❑ No

List the Professional Liability Insurance carried for each of the past five years including periods of no coverage.

Policy Period From: MM/DD/YY	To: MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Claims Made or Occurrence?	Premium
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addfr3 / /	/ /					
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If coverage is on a Claims Made basis , what is the retroactive date/prior acts date on your current policy?___

NOTE: THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS OR CIRCUMSTANCES EXIST WHICH MAY REASONABLY GIVE RISE TO A CLAIM UNDER THIS PROPOSED POLICY, THEN ANY CLAIMS ARISING FROM SUCH FACTS, INCIDENTS OR CIRCUMSTANCES ARE EXCLUDED FROM COVERAGE.

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. **COPIES OF ALL EMT MEDICAL DIRECTOR CONTRACTS WITH MUNICIPALITIES OR OTHER ENTITIES REFERRED TO IN THE APPLICANTS RESPONSE TO QUEESTION 8.**
2. **PROOF OF MEDICAL MALPRACTICE INSURANCE IF THE APPLICANT ALSO IS A PRACTICING PHYSICIAN**

SIGNATURE SECTION AND OTHER INFORMATION

NOTE: Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY BE ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

FRAUD WARNING: 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.

WASHINGTON FRAUD WARNING: 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.

<u>APPLICABLE IN THE STATE OF NEW YORK:</u> 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 CONTAINING 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.

_____

Name of Applicant

_____ _____

Signature and Title of Principal (must be owner, partner or officer) Date

_____

Print Name and Title of Principal Signing Above