MEDICAL PROFESSIONAL LIABILITY

PAIN MANAGEMENT SUPPLEMENTAL APPLICATION

The Applicant agrees that any coverage issued will be contingent upon the truth of the information provided in this application. If a policy is issued, this application will become a part of the policy, as if physically attached thereto.

Please fully complete this application as an incomplete application cannot be evaluated. Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply. Provide any supporting information on a separate sheet and reference the applicable question number. This application must be completed, dated and signed by an authorized representative of the applicant.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Aspen Specialty Insurance Company (the "Company") under any policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the policy, if and when issued.

APPLICANT GENERAL INFORMATION

Full Name of Applicant:_____

CERTIFICATION, TRAINING & EDUCATION

Have you completed any accredited, specialized training in pain management procedures? ☐ Yes ☐ No

If Yes, when: _____Please describe any accredited training relating to the procedures you perform as detailed in this supplement:_____

Are you currently a member of any recognized Board(s) relating to physician certification in the field of pain medicine? ☐ Yes ☐ No

If Yes, please list any board affiliations/certifications:_____

How long have you been performing pain management procedures? (*in years & months*)_____

PRACTICE INFORMATION

What percentage of your practice is devoted specifically to pain management:_____%

Please identify which types of procedures you perform, and indicate the # of procedures for each:

Procedure Type	***# performed last 12 months***	***# projected next 12 months***
☐ Drug Treatment (Opioids, Corticosteroids, antidepressants, anticonvulsants, etc.) *Indicate the number of annual Controlled Substance Prescriptions*		
☐ Acupuncture, Botox Injections, Manipulation (no anesthesia), Physical Therapy; *Please specify:*		
☐ Nerve Blocks; *Please specify:*		
☐ Joint Injections; *Please specify:*		
☐ Infusion Therapy; *Please specify:*		

☐ Epidurals, Spinal Catheters; *Please specify:*		
☐ Spinal Cord Stimulators; Kyphoplasty, Vertebroplasty, Other Spinal Column or Spinal Cord related injections, implants, surgeries or procedures; *Please specify:*		
☐ Procedures performed under General Anesthesia; *Please specify*:		
☐ Alternative Treatment(s), non-FDA approved drugs, PRP Therapy, Stem Cell Injections or other procedures; *Please specify:* *For Stem Cell Injections:* Do all treatments utilize autologous stem cells? Yes or No If No, please explain: Are injections limited to localized joint injections? Yes or No If No, please explain:		

If your practice includes Controlled Substance Prescriptions, do you have practice protocols in place to detect and prevent drug seeking behavior? ☐ Yes ☐ No

If Yes, please describe procedures/protocols:_____

_____

Are patients receiving pain medications required to sign a treatment contract/agreement? ☐ Yes ☐ No

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S PREMIUM INDICATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING PREMIUM INDICATION OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

_____ Date (Mo./Day/Yr.)

_____ Applicant Signature

_____ Print or Type Name

_____ Title

