A division of Palomar Insurance Corporation

A. APPLICANT (PLASTIC SURGEON) INFORMATION – PLEASE PRINT

1. Full Name: ______________________________

2. Desired Effective Date: ______________________________

B. OFFICE INFORMATION – PLEASE PRINT

1. Office Manager ______________________ Email ______________________

   Patient Registration ______________________ Email ______________________

   Accounting (to receive monthly invoices): ______________ Email ______________________

2. Business Name ______________________________

3. Primary Business Address ______________________________

4. Billing Address (if different) ______________________________

5. Office Phone ______________________ Fax ______________________

   Office Email ______________________ Web Address ______________________

6. Type of Practice: ☐ Solo Practitioner ☐ Group (2-4 Surgeons) ☐ Group (5 or more

   ☐ Multi-Specialty Group ☐ Academic Practice ☐ Other

8. Are you Board Certified by an ABMS Member Board? ☐ Yes ☐ No

   Name of Board(s) ______________________ Date Certified ______________________

9. If you answered NO to Question #8, are you ABMS Board Eligible? ☐ Yes ☐ No

   Name of Board ______________ Status ______________ Est. Date of Certification ______________

C. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please attach a current copy of your Medical Malpractice Insurance certificate.

1. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit for alleged malpractice? ☐ Yes ☐ No If yes have these been reported to your insurer? ☐ Yes ☐ No

NOTE: Please email or fax any claims information provided by your Medical Malpractice Insurance Company

2. Has your Medical Malpractice coverage ever been non-renewed or cancelled due to claims or nonpayment of premium? ☐ Yes ☐ No ***If Yes, please attach an explanation.***

TERMS AND CONDITIONS

As an applicant to be a Participating AI2 Surgeon, I ratify and affirm that I understand and agree that:

1. Only the below procedures are covered under the AI2 policy unless the policy is endorsed by the insurance carrier:

List of Covered Procedures

Brow Lift	Cheek Implants	Chin Augmentation	Chin Reduction
Cosmetic Eyelid Surgery	Facial Rejuvenation	Mandibular Implant	Otoplasty
Rhinoplasty	Hair Transplants		

2. Representatives of the insurer have the right to review and audit any records and/or records of the policyholder that may have a bearing on this insurance. This would include but is not limited to any individual patient file and/or a CPT-4 report and/or similar type of report.

3. The above-mentioned audit is to ensure there is compliance with the AI2 program policy provisions. If the audit determines that any patients were not reported and paid by the surgeon as required, then premium must be paid within 30 days.

4. Patients not covered by AI2 are not eligible for AI2 benefits.

5. There is no coverage in effect prior to the policy's effective date.

PLEASE READ AND SIGN. I hereby declare that the above statements are true and that I have not knowingly suppressed or misstated any material facts. I authorize the Company to conduct any investigation to substantiate this information. I hereby agree that this questionnaire including my attachments thereto shall be the basis of any insurance contract issued.

I agree to notify AI2 if there is any future material change in any answer to this questionnaire, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician, firm or professional association.

I understand and agree that the completion of this questionnaire does not bind the Company to issue, nor me to purchase, a contract of insurance, provided however, if I am issued insurance by the Company and I purchase such contract of insurance, I understand and agree that any material misrepresentation or omission by me in this questionnaire may act to void such contract of insurance and may give the Company a right to rescind such contract.

I understand and agree to abide by the aforementioned AI2 Terms and Conditions.

______________________________ ______________________________
Surgeon Signature Date Signed

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Print Name