Professional SOLUTIONS | INSURANCE COMPANY

Bariatrics Supplemental Application

A. APPLICANT INFORMATION

Name: _____
First Name Middle Last Name

Name of employer: _____

PSIC policy number (If applicable): _____

B. BARIATRIC PROCEDURE INFORMATION

1. Provide the number of each of the following procedures performed:
   - ❑ Bariatric in the past 12 months _____ in the past 24 months _____
   - ❑ General Surgery in the past 12 months _____ in the past 24 months _____
   - ❑ Endoscopy in the past 12 months _____ in the past 24 months _____
2. Do you practice at a facility that has a COE Certification? ..... ❑Yes ❑No
3. Do you have a qualified colleague with privileges to treat gastrointestinal disease to provide complete bariatric care of your patients in the event of your unexpected absence? ..... ❑Yes ❑No
   - Does the qualified colleague maintain 8 hours of bariatric-specific AMA PRA Category 1™ credits every 3 years? ..... ❑Yes ❑No

   Please provide the physician's name and attach a current Certificate of Insurance to this form..
4. Is a registered dietitian part of your program? ..... ❑Yes ❑No
5. Do you use only nursing or physician extenders who are certified by the ASMBS bariatric nursing program? ..... ❑Yes ❑No
6. Does the bariatric program have a designated bariatric coordinator, who is a CBN (certified bariatric nurse), to supervise program development, patient and staff education and compliance? ..... ❑Yes ❑No
7. Do you provide annual in-service training on the following: signs and symptoms of post-op complications, sensitivity training, patient transfer, mobilization training, patient education and informed consent process documentation to designated key personnel? ..... ❑Yes ❑No
8. Do you have a formalized educational program that describes and discusses all of the following: non-surgical weight loss efforts to be tried, a comparison of gastric banding, gastric sleeve, gastric bypass and biliopancreatic bypass in terms of mechanisms of weight loss, anatomic changes, complication types and rates, hospital stay, a described 6 week postoperative diet, and a guideline on postoperative supplementation of protein, vitamins and minerals? ..... ❑Yes ❑No
9. Do the hospitals where you have privileges to conduct bariatric procedures employ registered dietitians who see each patient when they are hospitalized? ..... ❑Yes ❑No
10. Do the hospitals where you have privileges to conduct bariatric procedures require emergency room physicians to undergo yearly education on evaluating bariatric patients in the ED? ..... ❑Yes ❑No
11. Do the hospitals where you have privileges to conduct bariatric procedures require radiologists on staff to undergo bariatric training to identify bariatric complications and the best modalities for evaluating a bariatric patient? ..... ❑Yes ❑No
12. Check all procedures you perform:
    - ❑Biliopancreatic diversion with duodenal switch
    - ❑Biliopancreatic diversion without duodenal switch
    - ❑Laparascopic adjustable gastric banding: ❑ Realize Band ❑ LapBand System
    - ❑Revisional bariatric surgery

B. BARIATRIC PROCEDURE INFORMATION (continued)

- ❑Roux-en Y gastric bypass
- ❑Sleeve gastrectomy
- ❑Urgent or emergent surgery due to complications from bariatric operations
- ❑Vertical banded gastroplasty

IF YOU ANSWERED "NO" TO ANY QUESTION BETWEEN # 2 AND 9, PROVIDE DETAILS IN SECTION E ON THE LAST PAGE.

C. REQUIRED DOCUMENTS

Please remember to attach a copy of the following:

- COE Certification
- Bariatric Surgery training certificate
- CME certificates
- Fellowship certificate
- Copy of formalized preoperative educational program materials

D. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC. In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except Oklahoma:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Signature of Applicant	Date
Signature of Agent	Date

E. ADDITIONAL INFORMATION

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE.

Professional SOLUTIONS INSURANCE COMPANY

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Clive, Iowa 50325-8258

Questions:
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Email: submissions@psicinsurance.com