Revised 8/2007

CosmetAssure

We Cover Complications.

Complications of Cosmetic Surgery Insurance

ENDORSED BY

AMERICAN SOCIETY OF PLASTIC SURGEONS

Questionnaire for ASPS Members and Candidates

Administered By:

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Please fax or overnight all Questionnaires to the address above.

**COSMETASSURE IS NOT AVAILABLE IN ALL STATES*

THIS QUESTIONNAIRE IS NOT FOR PROFESSIONAL LIABILITY INSURANCE

Coverage Underwritten By:
National Union Fire Insurance Company of Pittsburgh, Pa.
a member of
American International Companies®
Insurance Provided by Members of American International Group, Inc.

Instructions: Please type or print in ink all sections applicable to your surgical practice. If not applicable, please indicate N/A. Please attach requested documents.

A. APPLICANT (SURGEON) INFORMATION

1. Full Name: ____________________

2. Date of Birth: ____________________ 3. SS#____________________

B. OFFICE INFORMATION

1. Office Contact(s): Office Manager:____________________

Patient Representative:____________________

Accounting:____________________

2. Business Name: ____________________

3. Primary Business Address: ____________________

____

4. Billing Address (if different): ____________________

____

5. Office Phone: ____________________ Fax: ____________________

Email: ____________________ Web Address: ____________________

6. Type of Practice (circle): Solo Practitioner / Group (2-4 Surgeons**)** /Group (5 or more) / Multi-Specialty Group/ Academic Practice / Other_____________

7. Name all Board Certified Surgeons practicing with you that perform Aesthetic Surgery:

____________________ ____________________ ____________________

8. How did you hear about CosmetAssure? Please check all that apply.

____Internet
____CosmetAssure Representative Office Visit/ Phone Call
____Fellow Physician
____Advertisement (Please specify—i.e. Name of publication, direct mail, etc.)

____
____

____Conference {Please list Conference(s) name(s)}

____________________ ____________________
____________________ ____________________

____Other (Please list)

____________________ ____________________
____________________ ____________________

C. STATE LICENSURE AND CERTIFICATION (Please list the states where you hold a current medical license)

State	License Number	% of Practice	Status

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

Name of Board(s): ____________________Date Certified: ____________

____________________Date Certified: ____________

2. Are you ABMS Board Eligible? ☐ Yes ☐ No

Name of Board: ________________________________Status______________________Est. Date of Certification: ________

3. Have you ever been denied a medical license by any state, denied membership in a medical society, or denied certification by a specialty board? (If yes, an explanation on a separate sheet of paper must accompany this questionnaire) ☐ Yes ☐ No

4. Have you ever had your medical license, certification by a specialty board, membership in a professional society, or hospital privileges revoked, suspended or cancelled? (If yes, an explanation on a separate sheet of paper must accompany this questionnaire).
☐ Yes ☐ No

5. Are you a member of the American Society of Plastic Surgeons (ASPS)? ☐ Yes ☐ No
If No, are you a Candidate member of the ASPS? ☐ Yes ☐ No
Are you a member of the American Society for Aesthetic Plastic Surgery (ASAPS)? ☐ Yes ☐ No

D. SURGICAL PRACTICE DESCRIPTION
Please answer all questions fully. All "yes" answers should be explained in full. Attach additional sheets if necessary.

1. The following list of surgical procedures are **elective**, not reconstructive, and are covered under CosmetAssure. Please estimate the number of each procedure performed per year. **<u>A minimum of 15 patients having one or more of the below procedures in one anesthetic event must be estimated and performed.</u>**

Abdominoplasty______________	Cheek Implants______________	Lower Body Lift____________
Breast Augmentation__________	Chin Augmentation___________	Otoplasty_________________
Breast Lift___________________	Cosmetic Eye Surgery________	Rhinoplasty_______________
Breast Reduction_____________	Facelift __________________	Thigh Lift_________________
Browlift_____________________	Tx of Gynecomastia_________	Upper Arm Lift_____________
Buttock Lift_________________	Liposuction________________	Total/Year________________

Total Estimate of <u>Patients</u> having these any one or a combination of any of the above Covered Procedures during the next 12 Months:

☐

2. Please indicate where these procedures were performed in the last 12 months:
Hospital: ______% Accredited Surgical Center: ______% Office-Based Operating Room: ______% Other: ______%

3. For each <u>Accredited Surgical Center</u> (Outpatient Facility) and <u>Office Based Operating Room</u> referenced in question 2, list the facility and its accreditation (i.e. JCAHO, AAAHC, and AAAASF). For non-accredited facilities, please attach the most recent state inspection report if available.

Facility Name and Location:	Accreditation:	Contact Name & telephone #

4. Do you have staff privileges at a Hospital or Accredited Surgical Center for all of the procedures listed in Note 1 on page 3?
☐ Yes ☐ No If No, please explain.

5. Has any Hospital or Accredited Surgical Center ever restricted, suspended or revoked your privileges?
☐ Yes ☐ No

6. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice?
☐ Yes ☐ No

7. Has any fee or professional relations complaints been registered against you with your medical association, hospital, licensing authority or professional society? ☐ Yes ☐ No

NOTE: PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER EXPLAINING ALL "YES" ANSWERS.

E. PROFESSIONAL LIABILITY INSURANCE INFORMATION

1. Current Medical Malpractice Company ____Effective Date:____________

<u>***Note: Please attach the "Declarations" (front) page of your Medical Malpractice policy and a copy of your most recent certificate of insurance.</u>**

2. 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

<u>***Note: Please attach any claims information provided by your Medical Malpractice Insurance Company.</u>**

3. Has your Medical Malpractice coverage ever been non-renewed or cancelled due to claims or nonpayment of premium?
☐ Yes ☐ No

If yes, please provide details.____

____

____

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 by National Union Fire Insurance Company of Pittsburgh, PA ("the Company").

I agree to notify CosmetAssure 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 CosmetAssure Terms and Conditions.

_______________________________________ _____________________________
Signature Date Signed

CosmetAssure Binder

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

A. ALL of my patients having one or more of the 17 Covered Procedures listed below MUST be enrolled in CosmetAssure – there is no choice by the surgeon or the patient to accept or deny coverage.

B. CosmetAssure does not apply to those patients whose original procedure is either covered by other insurance or does not require general anesthesia or IV sedation.

C. 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.

D. Letter C above is to ensure there is compliance with the CosmetAssure 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.

E. Patients not covered by CosmetAssure are not eligible for CosmetAssure benefits.

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

______________________________	______________________________
Surgeon Signature	Witness Signature
______________________________	______________________________
Print Name	Print Name
______________________________	______________________________
Date Signed	Date Signed

<u>*List of Covered Procedures</u>

Abdominoplasty
Breast Augmentation
Breast Lift
Breast Reduction
Browlift
Buttock Lift
Cheek Implants
Chin Augmentation
Cosmetic Eyelid Surgery
Facelift
Treatment of Gynecomastia
Liposuction
Lower Body Lift
Otoplasty
Rhinoplasty
Thigh Lift
Upper Arm Lift

*Under general anesthesia or IV sedation only