Allied World Insurance Company ("Insurer")

Return to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

SUPPLEMENTAL APPLICATION FOR PSYCHIATRISTS' PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE

NEUROLOGY WITH PROCEDURES

- This Supplemental Application must be completed in full, including all required attachments. Write "None" if that applies.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant's needs.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. Name of Applicant: _____ Policy #: _____

II. NEUROLOGICAL PROCEDURES INFORMATION

2. Please indicate below all diagnostic and therapeutic neurological procedures that you perform and for which coverage is sought under this Policy:

   a. Diagnostic Neurological Procedures Performed:

Type of Procedure		*Performed?*		*If Yes, how often? (# per year)*
(i)	Lumbar puncture	☐Yes	☐No	
(ii)	edrophonium testing	☐Yes	☐No	
(iii)	ICP monitoring	☐Yes	☐No	
(iv)	Radiological studies, including: plain films, myelography, angiography, CT, isotope PET or SPECT or MRI	☐Yes	☐No	
(v)	Electroencephalography or Magnetoencephalography	☐Yes	☐No	
(vi)	Evoked Potentials	☐Yes	☐No	
(vii)	Polysomnography	☐Yes	☐No	

(viii)	Autonomic Function Testing	☐Yes	☐No	
(ix)	Electronystagmogram	☐Yes	☐No	
(x)	Audiometry	☐Yes	☐No	
(xi)	Perimetry	☐Yes	☐No	
(xii)	CSF Analysis	☐Yes	☐No	
(xiii)	Imaging with Ultrasound (Duplex, Transcranial Doppler)	☐Yes	☐No	
(xiv)	Other (list):	☐Yes	☐No	
(xv)	Other (list):	☐Yes	☐No	
(xvi)	Other (list):	☐Yes	☐No	

b. Therapeutic Neurological Procedures Performed:

Type of Procedure		*Performed?*		*If Yes, how often? (# per year)*
(i)	Endovascular embolization, including use of coil, balloon, stent or microcatheter	☐Yes	☐No	
(ii)	Surgical clipping	☐Yes	☐No	
(iii)	rtPA or other IV/IA thrombolytic treatment	☐Yes	☐No	
(iv)	Use of devices for treatment of stroke, including snares, balloon/stents, Angiojets, Neurojets, or other mechanical, photonic / acoustic clot retrieval / emulsification devices	☐Yes	☐No	
(v)	Carotid endarterectomy	☐Yes	☐No	
(vi)	Percutaneous transluminal angioplasty (PTA)	☐Yes	☐No	
(vii)	Intra-arterial papaverine injection	☐Yes	☐No	
(viii)	Transcranial Magnetic Stimulation (TMS or rTMS) or Deep Brain Stimulation (DBS)	☐Yes	☐No	
(ix)	Vagus Nerve Stimulation	☐Yes	☐No	
(x)	Other (list):	☐Yes	☐No	
(xi)	Other (list):	☐Yes	☐No	
(xii)	Other (list):	☐Yes	☐No	

Note: Any and all of the above procedures are subject to review and underwriting approval according to the Insurer's underwriting guidelines. This list does not provide any guidance regarding coverage that may or may not be available under the Policy as respects any claim. Actual coverage may vary and is subject to policy language as issued. Please refer to the actual policy form for all applicable terms and conditions. Not all procedures listed above may be eligible for coverage.

III. NOTICE TO APPLICANT

APPLICANT UNDERSTANDS THAT THE INFORMATION SUBMITTED IN THIS SUPPLEMENTAL APPLICATION BECOMES A PART OF THE APPLICANT'S APPLICATION FOR PSYCHIATRISTS' PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE AND IS SUBJECT TO THE SAME NOTICES, REPRESENTATIONS AND CONDITIONS SET FORTH IN SUCH APPLICATION.

IV. DECLARATION AND SIGNATURE

I UNDERSTAND THAT IT IS MY OBLIGATION TO MAINTAIN ANY LICENSE REQUIRED IN THE JURISDICTION(S) IN WHICH I PRACTICE.

Signed: _____

Print Name: _____

Title: _____
(Applicant/Owner/President of Corporation)

Date: _____

Supplemental Application must be signed, dated, fully completed and accompanied by the premium to be considered.

Producer Signature:

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694
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