



**SUPPLEMENTAL APPLICATION-BARIATRIC SURGERY  
FOR PROFESSIONAL LIABILITY INSURANCE  
PHYSICIANS AND SURGEONS  
CLAIMS-MADE COVERAGE**

***This supplemental application should be completed for your Bariatric Surgery practice only, unless otherwise indicated.***

*This supplemental application must be completed, signed and dated by any applicant who is performing bariatric surgery. Please complete this application in ink and answer all questions. An incomplete application cannot be processed. If a question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please attach a separate page. Where appropriate, also attach supporting documentation.*

**I. GENERAL INFORMATION**

Applicant's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

**II. EDUCATION AND TRAINING**

1. Are you currently certified by the American Society for Bariatric Surgeons (ASBS)?  Yes  No
2. Are you currently certified by the Society of American Gastrointestinal and Endoscopic Surgeons?  Yes  No
3. How long have you been performing bariatric procedures? \_\_\_\_\_ years \_\_\_\_\_ months

**III. PROCEDURES**

1. What percentage of your practice is bariatric surgery? \_\_\_\_\_%
2. At what locations do you perform bariatric surgery? \_\_\_\_\_  
Are the locations accredited and if so, by which organizations? \_\_\_\_\_
3. Please identify the type of bariatric surgical procedures performed: (check all that apply)

	Number of Procedures	
	Last 12 Months	Next 12 Months
<input type="checkbox"/> Open Adjustable Gastric Banding		
<input type="checkbox"/> Laparoscopic Adjustable Gastric Banding		
<input type="checkbox"/> Open Vertical Banded Gastroplasty		
<input type="checkbox"/> Laparoscopic Vertical Banded Gastroplasty		
<input type="checkbox"/> Open Standard Roux Gastric Bypass		
<input type="checkbox"/> Laparoscopic Standard Roux Gastric Bypass		
<input type="checkbox"/> Open Long-limb Roux Gastric Bypass		
<input type="checkbox"/> Laparoscopic Long-limb Roux Gastric Bypass		
<input type="checkbox"/> Open Biliopancreatic Diversion		
<input type="checkbox"/> Laparoscopic Biliopancreatic Diversion		
<input type="checkbox"/> Open Duodenal Switch		
<input type="checkbox"/> Laparoscopic Duodenal Switch		
<input type="checkbox"/> Other _____		

**IV. PATIENT SELECTION / INFORMATION**

1. Please provide your general patient selection and acceptance guidelines:
  - a. BMI: average \_\_\_\_\_
  - b. Patient age: youngest \_\_\_\_\_ years average \_\_\_\_\_ years
  - c. Please describe other selection and acceptance guidelines:  
\_\_\_\_\_
2. Please attach a copy of your Informed Consent form for bariatric procedures.
3. Please identify the types of pre-operative and post-operative support that you provide to your bariatric patients:
  - Nutrition Counseling
  - Respiratory Therapy
  - Mental Health
  - Other (identify) \_\_\_\_\_

**IV. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE**

This applicant declares that the information contained in this supplemental application is true and that no material facts have been suppressed or misstated.

The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations.

This applicant understands that incorrect information could void coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_