



Professional Liability Policy Renewal Application

All information below must be completed and all question answered “Yes” or “No”. Please correct any incorrect data.

Applicant’s Full Name	Social Security Number
Principal Office Address	Office Phone
	Office Fax
Other Office Address	E-mail Address
Mailing Address	
Medical Specialty	Renewal Date

Practice History: (Please explain all “Yes” answers in the “Remarks Section”)

1. Since your last application to us, have you been investigated or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency or has your license to practice medicine or your permit to prescribe or dispense drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? _____ Yes _____ No

2. Have any fee or professional relations complaints been alleged against you with your medical association(s), hospital(s) or any state licensing authority? _____ Yes _____ No

3. Since your last application to us, have your privileges at any hospital or other institution been Reduced, denied, revoked, restricted or suspended? _____ Yes _____ No

4. Since your last application to us, have there been any changes in your medical specialty, practice or procedures performed? _____ Yes _____ No

5. Please describe your patient load, hours practiced and insurance profile.
 - a) Average **weekly** patient load (number of patients seen):
 Current calendar year _____ Last calendar year _____ Calendar year before last _____
 - b) Number of hours practiced **weekly**:
 Current calendar year _____ Last calendar year _____ Calendar year before last _____
 - c) Percentage of patients who are:
 Medicare _____ Medicaid _____ No insurance _____

6. Have you formed a new corporation? If yes, name of corporation _____

7. Are you American Board Certified? If yes, specialty and date _____

8. Do you have any new professional associates (contracting, partners, etc)? _____ Yes _____ No

9. Do you employ any medical personnel? If so, please list them on reverse. _____ Yes _____ No

10. Since your last application to us, have there been any judgments, settlements, or dismissals of any previously reported claims, regardless of insurance carrier? _____ Yes _____ No

If "yes, please explain in the "Remarks" section below

11. Since your last application to us, have you become aware of any claims or suits; or fact or Circumstances, medical incidents, records requests, or letters of intent that may give rise to a claim or suit? **If yes, complete a Claims Information Form for each and indicate to what carrier, if any, the claim was reported.** _____ Yes _____ No

12. Have you been indicted or charged in a criminal suit? _____ Yes _____ No

13. Since your last application to us, have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine? _____ Yes _____ No

14. Do you provide services at a nursing home, skilled nursing facility or assisted living center? _____ Yes _____ No

a. If "Yes", what percent of patients: _____

b. If "Yes", do you treat other than your own patients at the facility? _____ Yes _____ No

15. List hospitals at which you are currently a staff member. If you would like a Certificate of Insurance sent to the hospital(s), please include the address.

Remarks Section: (Please indicate question number(s) referenced. Use a separate sheet if necessary.)

Question Number

Remarks

AGREEMENTS:

- I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not withheld any information which is calculated to influence the judgment of the Company in considering this application for renewal of my professional liability insurance. Erroneous and/or material misrepresentation will cause immediate recession of my insurance coverage.
- I understand that the policy being applied for does not cover liability of others which I may have assumed under any contract or agreement.
- I understand that completing a Claims Information Form with this application does not fulfill my obligation to provide notice of Claims, Suits or Incidents as required by the policy. I understand that I must abide by Section 6 NOTICE PROVISIONS in order to properly report a claim to the company.
- I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter and insurance agent to furnish any information concerning me or my medical practice that the company may request.
- Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

This application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature on the form does not bind the applicant or the Company to issue coverage. No renewal coverage exists until a deposit premium is paid to the Company, Broker, or Agent.

Applicant's Signature: _____ Date: _____

**AUTHORIZATION AND RELEASE OF LIABILITY
TO PROVIDE VERIFICATION OF COVERAGE AND CLAIMS HISTORY**

I hereby consent to and authorize the release to any Hospital, PPO, IPA, HMO, Credentialing Agency, etc., by any representative of CARE Risk Retention Group, information and documents that may be relevant to a verification of my professional liability insurance and/or claims history. I agree that any person or organization furnishing information pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information. This release is submitted as part of my application and will remain in effect until revoked by me in writing.

Applicant's Signature: _____ Date: _____