Renewal Application

Applicant Information

1. Full name: _____

2. E-Mail address: _____

3. Primary practice address (Please list all locations and entities for which you are requesting coverage in the Remarks Section):

_____

4. Office phone number:_____Office fax number:_____Primary contact number: _____

Practice Information

5. Primary specialty:_____Percentage of practice: _____

6. Secondary specialty:_____Percentage of practice: _____

7: Please indicate your average number of practice hours per week that will be covered by this policy, including office hours, administrative activities, direct patient care, surgery, consultations, etc..:_____Number of patients seen on a weekly basis: _____

Insurance Information

8. Have there been any changes to your practice within the last 12 months? Please include changes in employees or independent contractors, procedures performed, drug study participation and treatment for alcohol or drug abuse.

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

9. Are you aware of any potential compensable evens resulting from patient care?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

10. Has any patient expressed disappointment or discontent with services or procedures provided by you or anyone in your office?

☐ Yes ☐ No *If yes, please provide copies of complaint and disposition documents*

11. Have you received a request for patient records from an attorney?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

12. Have you been subject to any investigation or had any disciplinary actions filed against you?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

13. Have any awards or settlements been paid on your behalf for claims which were previously open with a prior insurance carrier?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

14. Did you function as a Medical Director for any facility? If yes, provide the name of the facility and length of time you have been there. Do you admit patients for the above facility?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

Remarks Section

Disclaimer and Signature

GENERAL FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA FRAUD WARNING: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FLORIDA FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

TEXAS FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The undersigned, acting on behalf of all proposed Insureds, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each Insured proposed for this insurance to facilitate the proper and accurate completion of this Application. The undersigned agree that the particulars and statements contained in this application and any material submitted herewith are their representations and are the basis of the insurance contract. The undersigned further agree that this application and any material submitted herewith shall be considered attached to and a part of the Policy. Any material submitted with this application shall be maintained on file (either electronically or paper) with the Insurer and shall be deemed to be attached hereto as if physically attached. It is further agreed that: (1) if any significant change in the condition of the applicant is discovered between the date of this application and the Policy inception date, which would render this application inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately and, upon receipt of such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance; (2) any Policy, if issued, will be in reliance upon the truth of such representations and any misrepresentation by the Insured or the Insured's agent that is material to the acceptance of the risk will render the Policy null and void and relieve the Insurer from all liability herein; (3) this application has been completed as respects the entire Applicant; (4) the signing of this application does not bind the undersigned to purchase the insurance.

I understand that the information submitted herein becomes a part of the Applicant's Professional Liability Insurance Application and is subject to the same representations and conditions.

Signature: _____

Print Name: _____

Date: _____

Please submit the following with the application: Current Loss Runs for all claims