DOCTORS & SURGEONS NATIONAL RISK RETENTION GROUP
APPLICATION FOR CLAIMS MADE PROFESSIONAL LIABILITY INSURANCE

THIS POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSOLVENCY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP

PRINT OR TYPE ALL INFORMATION

Although not all questions are applicable to you, please do not leave any questions unanswered. Write NONE or N/A when the question does not apply to you.

REQUESTED EFFECTIVE DATE_____12:01AM

_____MD/DO/___ _____ _____
1. Name of Applicant (Circle title or insert title) 2. Telephone 3.Fax

_____
4. Office Street address County City State Zip code
(Additional office addresses should be written on the last page of this form.)

5. Specialty: _____Surgery? Major/Minor/ None (Please circle one).
5a. Sub-specialty _____Surgery? Major/Minor/ None (Please circle one).

_____ _____ _____
6. Date of Birth 7. Social Security Number 8. Dates of present policy

_____ _____
9. Present Carrier—please attach copy of your policy's declarations page. 10. Retroactive date

11. Do you practice Full Time Part Time 11a. TOTAL Number of hours worked per week: _____
11b. How many patients do you see per week? _____

12. Type of Practice: Individual_____ ; Member of Professional Corporation _____ ;
Partnership _____ ; Partnership Association _____ ; Other _____

13. If employee, Name of Employer: _____

14. Name of Corporation, Professional Association or Partnership: _____

15. Is the entity named in #14 to be added as a named insured?** YES NO (If yes, attach Articles of Incorporation.) Will this entity share your limits or carry separate limits? Shared limits/Separate limits.

16. List all names of partners or members of the corporation or association:
_____
_____
_____

17. Professional employees (if insured, please provide professional liability policy number for each):

NAME	JOB DESCRIPTION	POLICY NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

18. Have you participated in any continuing education programs in the last five years? YES NO

If yes, provide details_____
_____

19. _____
Hospital(s) where you practice and/or have privileges County City

UNDERWRITING INFORMATION:

Please attach a copy of your CV or resume listing the colleges you have attended, dates and degrees.

1. Postgraduate education:
   (a) Internship: YES NO Hospital _____
   Address (City & County) _____Dates _____

   (b) Residency/ Fellowship/ Preceptorship: YES NO Hospital _____
   Address (City & County) _____Dates _____

2. Board Certification: YES NO If yes, name of Board _____Year Certified_____

3. Current Licenses:

STATE	LICENSE NUMBER	DATE	EXAM REQUIRED	DATES TAKEN
			Yes/No	
			Yes/No	

4. Have you ever had a license revoked or suspended, or have you been put on probation? YES NO
   If yes, please explain: _____

5. Have you ever had a narcotic license revoked or suspended, or have you been on probation? YES NO
   If yes, please explain_____

6. Have you ever had your privileges denied, suspended, restricted, revoked or not renewed? YES NO
   If yes, please explain _____

7. List ALL malpractice carriers for the past 5 years:

DATES	NAME	COVERAGE (occurrence/ claims made)
_____to_____	_____	_____
_____to_____	_____	_____
_____to_____	_____	_____
_____to_____	_____	_____
_____to_____	_____	_____

8. List ALL facilities where you do surgery or consultations:

NAME	ADDRESS	YEARS AT FACILITY	ADMINISTRATOR

9. Please attach delineation of privileges at each facility. Do you ever perform surgery that is not your delineation? YES NO
10. Have you ever used any intoxicant, or other psychoactive or depressant drug to the extent that it has interfered with your ability to perform professional duties? YES NO
11. Have you ever had any professional liability insurance declined, cancelled or renewal refused, for reasons other than the company's withdrawal from your professional liability market? YES NO

12. Have you ever had professional liability insurance issued on a restrictive basis (i.e. reduced limits, assigned a deductible, restrictive coverage, surcharge rates)? YES NO
13. Have you ever been the subject of disciplinary proceedings or been reprimanded by an administrative agency, hospital or professional association? YES NO
14. Have you ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? YES NO
15. Have you ever been treated for alcoholism or drug addiction? YES NO
16. Have you ever been disabled or had an interruption of your practice because of a disability? Yes NO
17. Do you work for or in a prison? YES NO

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, PLEASE EXPLAIN: _____

_____

_____

_____

_____

18. Do you administer any sedatives, analgesics or anesthesia (besides Xylocaine) in your office?

YES NO If yes, please explain:

_____

_____

19. Do you participate in any of the following?

Sports medicine? YES NO Minimal incision surgery? YES NO
Emergency room work? YES NO Laser Surgery: YES NO If yes,
(a) What type of treatment? Explain: _____
_____

(b) How many times a week do you use the laser?_____
(c) What type of training did you receive in the use of the laser? (check all that apply)
_____Seminar _____Course _____ Preceptorship _____ Hands-on_____ other

(d) Please specify names of programs_____

20. Who obtains your informed consent? _____
21. How many patient contacts do you have per week? _____
22. Have you attended a malpractice loss prevention program in the last 12 months? YES NO
If yes, when, where and please describe:
_____

CLAIMS INFORMATION:

23. Are you now, or in the LAST 10 YEARS, have you been involved directly or indirectly in a claim, potential claim or suit arising out of rendering or failing to render professional services? YES NO
If yes, how many? _____ Have these been reported to your insurer? YES NO

24. Do you have knowledge of any incident or unexpected adverse outcome in which you may become involved, which may result in a claim? YES NO If yes, how many? _____ Have these been reported to your professional liability carrier? YES NO (If yes, please attach copy of report or information reported.)

I hereby declare and represent that the above statements and particulars are true and complete. I have not withheld or misstated any information. I understand and agree that the information contained in this application is material; that it is being relied upon by Doctors & Surgeons National Risk Retention Group

("the company") in considering my application for professional liability insurance; and that it is the basis of any policy of insurance which may be issued to me. I also understand that this application shall be annexed to, and deemed a part of, any policy of liability insurance issued to me by the company.

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any false information or conceals, for the purpose of misleading others, any material fact, commits a fraudulent insurance act which is a crime.

IT IS FURTHER UNDERSTOOD AND AGREED BY ME THAT THERE SHALL BE NO COVERAGE FOR CLAIMS MADE OR CLAIMS ARISING FROM INCIDENTS OCCURRING DURING THE POLICY PERIOD WHICH IS ISSUED UPON THIS APPLICATION, IF ANY OF THE FOLLOWING CONDITIONS APPLY:

(1) The claim arises out of the performance of any procedure or surgery not indicated by me in this application.
(2) The claim arises from the rendering of the professional services outside the scope of the specialty or the sub-specialty stated by me in this application.
(3) Knowledge of or notification of the claim or an incident has occurred prior to the date below of this application.
(4) The claim arises from professional services rendered outside the classification applied for in this application as defined in the classification and rate sheet.

_____	_____	_____
Date	Print Name	Signature of Applicant

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any person, company, insurer, hospital or other organization to release any and all information privileged or not, in their dominion, custody, or control regarding any insurance application by me, professional liability insurance issued to me, claims made or suits brought against me, applications by me for hospital privileges, decisions, and notes of any credentials or disciplinary committees involving me, any employment of personal records involving me, any records involving me as well as any information obtained by any attorneys who are now representing me, of have in the past represented me. I hereby authorize you to make copies of this application as you deem necessary and those copies shall be as valid as originals.

_____	_____	_____
Date	Name (Print or Type)	Signature

Add additional office addresses here: _____
_____

Agent's name and address: _____
_____

Please answer the questions on the **Supplementary application form** if you practice in: cardiology; cosmetic surgery; dermatology; family/general practice; general, vascular or thoracic surgery; gynecology; hand surgery; hospitalist services; ophthalmology; otorhinolaryngology; orthopedics; pathology; plastic surgery; physical medicine and rehabilitation; radiology/nuclear medicine; or urology.
Please answer the questions on the **Additional Insured application form** if you wish to insure your nurse midwife; nurse practitioner; nurse anesthetist; acupuncturist; psychologist; occupational/physical therapist; or an additional physician.