



## CARE Application Checklist

Please answer **ALL** questions; if question is not applicable state n/a.

- Complete Application
- Completed claim form for every previous medical malpractice claim
- Curriculum Vitae
- Declaration sheet from your current carrier
- Copy of your license(s)

### APPLICANT'S INSTRUCTIONS:

1. Answer all questions; if a question is not applicable, state NOT APPLICABLE or N/A.
2. If space is insufficient to answer any questions fully, please use the Remarks Section.
3. The Application must be signed and dated by the applicant.
4. If the answer to any question is none, state "NONE".
5. Please do not complete the application earlier than 30 days before proposed effective date of coverage.

Preparers Signature x \_\_\_\_\_ Date \_\_\_\_\_

*This application asks you to provide information regarding hospital affiliations, practice associations, etc. This information is requested to provide us with an understanding of your practice but does not mean that a policy, if issued, would cover such entities or persons.*

**APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR  
PHYSICIANS AND SURGEONS**

**THIS IS FOR A CLAIMS MADE AND ASSERTED POLICY**

**I. YOUR INFORMATION**

1. A. Full Name of Individual Applicant: \_\_\_\_\_ MD \_\_\_ DO \_\_\_

B. Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

C. Are you a U. S. Citizen? \_\_\_\_\_ If "no" please indicate your status and entry into the U.S. in the Remarks Section. Include a copy of your current or Permanent Visa.

D. Email Address \_\_\_\_\_  
We will not sell, license, transmit or disclose your email information outside of CARE.

2. A. Principal Office Address:

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone #: \_\_\_\_\_

B. Mailing Address: (All correspondence from CARE will be sent to the principal address unless otherwise noted)

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone #: \_\_\_\_\_

C. Residence Address:

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone #: \_\_\_\_\_

D. Other Offices: (Please attach the Remarks Section for additional office locations)

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone #: \_\_\_\_\_

If more space is needed, please complete in remarks section.

E. Limits of Liability Desired: \_\_\_\_\_  
(Limits in policy will govern coverage)

Desired Effective Date: \_\_\_\_\_  
(12:01 a.m.)

**II. PRIOR ACTS COVERAGE**

- 1. Prior Acts Coverage would provide protection for claims made and asserted that 1) are first reported to CARE after the Policy Effective Date with CARE and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or Expiration Date of that policy. Do not forfeit your right to purchase Extended Reporting Period Coverage (“Tail Coverage”) from your current carrier.

Please check one:

\_\_\_ I wish to apply for Prior Acts Coverage. (Please identify the Requested Retroactive Date below, **which must be the same as the Retroactive Date on your current policy**)

\_\_\_ I **do not** wish to apply for Prior Acts Coverage. I understand that if I do not obtain Prior Acts Coverage, I will have no coverage with CARE for claims arising from any acts or omissions that occurred prior to the Effective Date of my CARE policy, if issued.

**Requested Retroactive Date:** \_\_\_/\_\_\_/\_\_\_

**III. CURRENT PRACTICE**

- 1. Provide the formal corporate, association, partnership or business name and Tax ID#:

\_\_\_\_\_

- 2. Would you like vicarious coverage for the above entity? \_\_\_ Yes \_\_\_ No

- 3. List all states where you are licensed to practice:

State \_\_\_ License # \_\_\_ Permanent or Temporary? \_\_\_\_\_

State \_\_\_ License # \_\_\_ Permanent or Temporary? \_\_\_\_\_

State \_\_\_ License # \_\_\_ Permanent or Temporary? \_\_\_\_\_

If licensed in additional states, please use the Remarks Section.

- 4. Do you practice outside of your primary state? \_\_\_ Yes \_\_\_ No

If yes, list additional states \_\_\_\_\_

- 5. Please indicate if you would like coverage for additional states? \_\_\_ Yes \_\_\_ No

If yes, list each state \_\_\_\_\_

- 6. List hospitals at which you are currently a staff member and show % of work at each hospital:

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

- 7. Briefly describe type & extent of your hospital privileges: \_\_\_\_\_

\_\_\_\_\_ Temporary \_\_\_\_\_ Permanent

8. Are you Chief or Head of a hospital department?  Yes  No  
 If yes, please explain in detail. \_\_\_\_\_  
 \_\_\_\_\_
9. Are you a medical director at any other facility other than a long-term care facility?  Yes  No  
 If yes, please complete the Medical Directorship Supplement.
10. Do you own (wholly or in part), operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? \_\_\_\_\_  
 If "yes" provide details, including name, location, size and number of beds in the Remarks Section.
11. Medical Specialty: \_\_\_\_\_ % of Practice: \_\_\_\_\_  
 Sub-Specialty: \_\_\_\_\_ % of Practice: \_\_\_\_\_
- Average **weekly** patient load (Number of patients seen):  
 Current calendar year \_\_\_\_\_ Last calendar year \_\_\_\_\_ Calendar year before last \_\_\_\_\_
- Number of hours practiced **weekly**:  
 Current calendar year \_\_\_\_\_ Last calendar year \_\_\_\_\_ Calendar year before last \_\_\_\_\_
12. Do you practice **outside** of your main office location?  Yes  No  
 If yes, please provide type of facility, (e.g. nursing home, rehab center, and location):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Number of years at current office location: \_\_\_\_\_
13. Have there been any significant changes in your practice during the past 5 years (i.e. changes in specialty, changes in location, addition or deletion of procedures, etc.)?  
 Yes  No If "Yes", please use the Remarks Section.

**IV. LONG TERM CARE FACILITIES**

1. Do you provide any services at a Long-Term Care facility?  Yes  No  
 If yes, please complete the following:
- |                           |  |   |
|---------------------------|--|---|
| Skilled Nursing Facility  | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what percentage of your practice? _____ % |
| Assisted Living Center    | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what percentage of your practice? _____ % |
| Independent Living Center | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what percentage of your practice? _____ % |
- a. If "Yes", do you treat patients other than at your own facility?  Yes  No
2. Are you a medical director at a long term care facility such as a skilled nursing facility, assisted living center or independent living center?  Yes  No  
 If yes, please complete the Medical Directorship Supplement
3. Does the nursing home have professional liability coverage?  Yes  No  
 If yes, please provide a copy of the Certificate of Insurance.

**I. MEDICAL PROCEDURES AND PATIENT CARE**

1. Check the appropriate box, indicating the extent of surgery you perform:

- No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing of minor lacerations # Annually \_\_\_\_\_
  - Minor Surgery – Includes circumcisions other than on newborns and vasectomies # Annually \_\_\_\_\_
  - Major Surgery – Includes all procedures done under general, spinal or caudal anesthesia # Annually \_\_\_\_\_
  - Assisting in surgery on your own patients # Annually \_\_\_\_\_
  - Assisting in surgery on patients other than your own # Annually \_\_\_\_\_
- If any of the above applies, please complete the General Surgery & OB supplement to this application.**
- Hospitalist # Annually \_\_\_\_\_
  - Perform obstetrical procedures # Annually \_\_\_\_\_

2. Do you perform surgery in your office? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If “yes” list surgical procedures in the remarks section.

3. Do you perform any type of pain management in your practice, i.e., the diagnosis, management and/or treatment of chronic pain including the prescribing of pain medications? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If “yes” please explain in the remarks section.

4. If you answer “yes” to question 3 please answer a,b,& c below.  
a. What percentage of your patients are treated for pain management? \_\_\_\_\_ %  
b. What percentage of those patients are prescribed schedule III controlled substances? \_\_\_\_\_ %  
c. Please complete the Pain Management Supplement.

5. Do you practice any type of Addiction Medicine? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If “Yes”, please use the Remarks Section.

6. Do you prescribe medical marijuana? \_\_\_\_\_ Yes \_\_\_\_\_ No

7. Indicate number of hours per month devoted to hospital emergency room care, if any:  
a. Is this emergency room care:  
1. On your own patients only? \_\_\_\_\_  
2. Required for staff privileges? \_\_\_\_\_  
3. Other (details) \_\_\_\_\_

**If you are practicing emergency medicine, please complete the Emergency Medicine supplement**

8. Do you perform surgery in other non-hospital facilities? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If “yes” list facilities and surgical procedures

- a. In the course of surgery, is general anesthesia administered? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - 1. By you?
  - 2. By others?

9. Do you practice weight reduction or control (other than by diet-exercise)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
a. Do you prescribe or administer HCG? \_\_\_\_\_ Yes \_\_\_\_\_ No

**If “yes”, please complete Bariatric supplement to this application only if you are a Bariatric Surgeon.**

10. Do you participate in any activity, (e.g., newspaper columns, broadcasts, etc.,) whereby professional advice is offered to the public? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If “yes” please provide an explanation of this activity in the Remarks Section.

Primary Assisting

- Acupuncture or Acupressure
- Adenoidectomies
- Angiography, Angioplasty, Arteriography, Cardiac Catheterization
- Banding Hemorrhoids
- Bronchoscopy
- Circumcision – Other than newborn
- Colonoscopy
- Cryosurgery
- Electro Convulsive Therapy
- Endoscopic Procedures
- Endoscopic Retrograde Cholangiopancreatography
- Esophageal Gastro Dilation
- Fertility / Infertility Treatment
- Hemorrhoidectomy
- Hyperbaric Chamber Treatment
- Hypnosis
- Insertion of intrauterine or subcutaneous contraceptive devices
- Laparoscopy
- Lasers – used in therapy or surgery
- Lumbar Puncture - # per year \_\_\_\_\_
- Needle Biopsy
- MOHS Microscopic Surgery
- Office x-rays – Over read:  Yes  No By whom: \_\_\_\_\_
- Open Reductions of Fractures
- Prenatal Care
- Radial Keratotomy, LASIX, PRK, AKL, or PTK
- Radiology Diagnostic  
 # Reads/week\_\_\_\_\_. Mammograms:  Yes  No . If “yes”, #/month\_\_\_\_\_.

- Radiation Therapy
- Spinal Anesthesia
- Spinal Surgery
- Thoracic Surgery \_\_\_\_\_%
- Trigger Point Injections (Neck and Spine:  Yes  No)
- Vasectomies
- Any procedures not customary to your specialty: \_\_\_\_\_

**VI. EMPLOYEES**

1. List number and type of professional employees: **If none, check here:**

- |  |                             |
|--|-----------------------------|
| _____ Physicians (other than yourself)   | _____ Surgeons Assistants   |
| _____ Nurse Practitioners  | _____ Physicians Assistants |
| _____ Nurse Midwives   | _____ Nurse Anesthetist     |
| _____ Other (describe duties in detail, including extent supervised, in the Remarks Section) |                             |

2. Are all of the above individuals licensed in accordance with applicable state and federal regulations?  
 \_\_\_\_\_ If “no”, use the Remarks Section for explanation.  
 \_\_\_\_\_ Do you want coverage for any of the above employees?  
 If “yes” please provide names in the Remarks Section.

PROVIDE A DETAILED ANSWER TO ANY “YES” ANSWERS USING THE REMARKS SECTION.

3. Have you or any of the above employees:
- a. Ever been the subject of investigation or disciplinary proceedings or reprimand by a governmental or administrative agency hospital or professional association? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - b. Ever been convicted of an act committed in violation of any law or ordinance other than traffic offenses? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - c. Ever been treated for alcoholism, drug addiction or undergone personal psychiatric treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - e. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - f. Ever failed any medical licensing or specialty organization examination? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - g. Have any chronic physical illness or defect? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - h. In the last 2 years, have you been treated for any neurological, mental or emotional problems?  
 \_\_\_\_\_ Yes \_\_\_\_\_ No
  - i. In the last 2 years have you been diagnosed with any new medical condition that could affect your practice of medicine? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - j. In the last 2 years, have there been any significant changes in your vision? \_\_\_\_\_ Yes \_\_\_\_\_ No

***Reminder: Please use the Remarks Section for any “yes” answers to the above***

4. Do you supervise any individuals other than your own employees? \_\_\_\_\_ If "yes" provide a detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also indicate, by profession the number of individuals supervised.

TYPE OF PROFESSION                  NUMBER

Physicians                                  \_\_\_\_\_

X-ray Technicians                          \_\_\_\_\_

Laboratory Technicians                          \_\_\_\_\_

**Do you need coverage for any of these ancillaries? \_\_\_\_\_ Yes \_\_\_\_\_ No**

5. Are you in the employ of any individual, firm or corporation other than your own? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes", please outline in the Remarks Section.

6. Are you under contract to any individual, firm or corporation other than your own? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes", please outline in the Remarks Section.

If this contract contains a hold-harmless agreement, a copy of the contract must be attached to the application.

7. Are you in the employ of any governmental entity? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes", please outline in the Remarks Section.

8. Are you under contract to any government entity? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes", please outline in the Remarks Section.

9. Do you advertise your professional services in any manner (other than a simple listing in the telephone directory)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes", please explain in the Remarks Section.

10. Are you associated with any agency or organization that engages in any kind of advertising for solicitation of patients? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "yes", please explain in the Remarks Section.

11. Do you treat any professional athletes or celebrities? \_\_\_\_\_ Yes \_\_\_\_\_ No

## **VII. EDUCATION**

1. From what medical school did you graduate? \_\_\_\_\_  
Degree: \_\_\_\_\_ Year: \_\_\_\_\_  
Location of Medical School (City, State, Country): \_\_\_\_\_

If foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates? \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes". state year and describe: \_\_\_\_\_

2. Residency? \_\_\_\_\_ If "yes" complete the following for each residency served:

Location: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Type: \_\_\_\_\_ Did you complete? \_\_\_\_\_

Location: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Type: \_\_\_\_\_ Did you complete? \_\_\_\_\_

Location: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Type: \_\_\_\_\_ Did you complete? \_\_\_\_\_



**VIII. PRACTICE LOCATIONS**

1. Do you practice in a surgi-center, abortion clinic, drug control clinic, emergi-center, extended hours walk in clinic or birthing center?

If "yes.", state location and describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IX. PROFESSIONAL AFFILIATIONS**

1. Indicate membership in professional societies:

- a. American Board of Medical Specialties: \_\_\_\_\_
- b. Special Medical Societies: \_\_\_\_\_
- c. Specialty Colleges: \_\_\_\_\_
- d. County Medical and Others: \_\_\_\_\_

**X. CLAIMS AND COVERAGE HISTORY**

1. Have you received any communication/request for information from an attorney, a court of law, patient, patient family member or patient representative regarding medical services you performed?

\_\_\_\_\_ Yes \_\_\_\_\_ No

*If "yes" A Supplemental Claims Information Form must be completed for each incident or occurrence.*

a. Have any claims or suits for alleged malpractice ever been brought against you? \_\_\_\_\_ Yes \_\_\_\_\_ No

Total Number of Claims: \_\_\_\_\_ Open: \_\_\_\_\_ Closed: \_\_\_\_\_

b. Have you reported all circumstances, medical incidents or records requests that may reasonably give rise to a complaint, claim or a suit to your current carrier? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ None to report

*If "no", please explain. If "yes", please complete a Supplemental Claims Information Form for each incident or occurrence explaining the circumstances.*

**XI. PRIOR COVERAGE SUMMARY**

1. List prior professional liability insurance carried for each of the past ten years. If none, list none.

Insurer	Policy Limit	Deductible	Expiration	Claims Made or Occurrence

2. Does your practice require or ask your patients to sign an arbitration agreement? \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes", please attach a copy of that agreement.



**Notice to Indiana Applicants:** Any person who knowingly and with intent to defraud an insurer files an application for coverage or a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Notice to Kentucky Applicants:** By statute, warranties are deemed representations. Misrepresentations, omissions, and incorrect statements shall not prevent a recovery under the policy or contract unless either: (1) Fraudulent; or (2) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or (3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required by the application for the policy.

**Notice to Maryland Applicants:** Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to Michigan Applicants:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for coverage statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

**Notice to New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Notice to New York Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Notice to Ohio Applicants:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Notice to Oklahoma Applicants:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes an claim for the proceeds of any insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

**Notice to Pennsylvania Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Notice to Tennessee Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Notice to Virginia Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Notice to Texas Applicants:** Pursuant to Chapter 705 of the Texas Insurance Code, the company may void the policy only in the event of material misrepresentations in the application, and it must be shown at trial that such misrepresentations were material.

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 3 of this application to present date have been reported to my current insurance carrier.

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to the Company prior to the effective date of such coverage and are listed previously or by supplemental form attached below.

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## **WARRANTY**

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy coverage excess of this policy. Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains to my background, competence and qualifications.

ACKNOWLEDGED AND AGREED: \_\_\_\_\_

APPLICANT (Signature Required): \_\_\_\_\_ Date: \_\_\_\_\_

Signing this application does not bind the Company to complete the insurance. All information requested in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AND ASSERTED AGAINST THE INSURED while the policy is in force. Furthermore the policy includes the cost of defense of claims within the policy limit which means that the Policy limit available to pay a claimant WILL be reduced by the cost of investigation, defense and other expenses involved in the defense unless otherwise stated in the policy documents. The applicant, by signing this application above confirms (his/her) understanding of all provisions represented by the Insurer.

**ASSIGNMENT OF RIGHT TO CANCEL COVERAGE**

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

Yes  No

If “yes”, please read and approve the following statement:

By my signature, I assign to the following employer or named third party (include name and address) both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-502-895-6406 or sending written notice to CARE Risk Retention Group, Inc., 9300 Shelbyville Road, Suite 204, Louisville KY 40222.

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature of Insured: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE NOTE: YOUR RIGHT TO CANCEL AND RECEIVE A PREMIUM REFUND WILL AUTOMATICALLY BE ASSIGNED THROUGH YOUR AGENT TO A THIRD PARTY FINANCE COMPANY IF IT PAYS YOUR PREMIUM ON YOUR BEHALF.**



**Professional Liability Claims Information**

(Must be printed or typed)

*Complete one form for each case. Copies may be made as needed*

**Insurance Carrier:** \_\_\_\_\_ **Patient Name:** \_\_\_\_\_

**Date of Occurrence:** \_\_\_\_\_ **Date of Suit:** \_\_\_\_\_

**Location of Incident:** \_\_\_\_\_

**Relationship to Patient (attending physician, surgeon, consultant, etc.)**

\_\_\_\_\_

**Primary Defendant:** \_\_\_\_\_ **Co-Defendant:** \_\_\_\_\_

**Patient Outcome:** \_\_\_\_\_

\_\_\_\_\_

**Allegations made about care rendered:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Claim Status (Open, Closed, Pending):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If closed, indicate method of closing: (Circle below)**

**DISMISSAL**

**SETTLED**

**JUDGMENT**

**CASE-DROPPED**

**Amount of settlement/judgment:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician (print name):** \_\_\_\_\_ **Date:** \_\_\_\_\_

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_