CARE
Professional Liability Association, LLC
RISK RETENTION GROUP, INC.

Professional Liability Policy Renewal Application

All information below must be completed and all questions answered. If question is not applicable state n/a. Please correct any incorrect data.

_____
Applicant's Full Name

Has your address, email, phone number, or specialty changed since your last renewal? ____Y ____N

If yes, please provide new information: _____

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? _____Yes _____No
2. 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
3. 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
4. Since your last application to us, have your privileges at any hospital or other institution been reduced, denied, revoked, restricted or suspended? _____Yes _____No
5. Have you ever been convicted or accused of Medicare or Medicaid fraud? _____Yes _____No
6. Since your last application to us, have there been any changes in your medical specialty, practice or procedures performed? _____Yes _____No

IMPORTANT - PLEASE REVIEW

If the information on your current supplement has changed in <u>any</u> way, (e.g. new procedures, new surgeries or new treatments) you are required to complete a revised supplement form. Please note: The supplement we have on file is incorporated into and deemed a material part of your policy. Any changes in procedures, surgeries or treatments not disclosed in your supplement could affect your coverage. Therefore, the information we have on file must be accurate and current.

7. Please describe your patient load, hours practiced & insurance profile:

   a) Average number of <u>patients</u> you see & hours you practice **<u>weekly</u>** : (**EXAMPLE**: Current calendar year <u>40pts/48 hrs</u>)

   Current calendar year _____ Last calendar year _____ Calendar year before last _____

8. Have you formed a new corporation? If yes, provide name of corporation_____
   Do you want this corporation added to your policy? _____Yes _____No
9. Are you American Board Certified? If yes, provide specialty _____
10. Do you have any new professional associates (contracting, partners, etc)? _____Yes _____No
11. Do you employ any medical personnel? ___Yes ____No. If yes, do you want coverage for them? ____Yes ____No

    If "yes", include name(s), title(s) and coverage needed in the "Remarks Section"

12. 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
13. Since your last application to us, have you or your office/practice received any communication and/or records request from an attorney, a court of law, a patient, a patient family member or patient representative regarding medical services you or your office/practice performed or have any claims or suits for alleged malpractice been brought against you or your office/practice or are you or your office/practice aware of any circumstances, medical incidents or records requests that may give rise to a claim or a suit? _____Yes _____No

If "yes" to any part of question 13, please disclose the nature of the communication or occurrence in the "Remarks" section below. Use a separate sheet if necessary.

14. Have you or anyone in your office/practice been indicted or charged in a criminal suit? _____Yes _____No

15. Does your practice require its patients to sign an arbitration agreement?
    a.) If "yes", please attach a copy of that agreement. _____Yes _____No

16. 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

17. Do you provide services at a:
    Skilled Nursing Facility _____Yes _____No If "yes", what percentage of your total patients? _____
    Assisted Living Center _____ Yes _____No If "yes", what percentage of your total patients? _____
    a.) If "Yes", do you treat patients other than at your own at any facility? _____Yes _____No

18. Are you a medical director at any facility? _____Yes _____No

19. List hospitals, long term care facilities and all other medical facilities at which you are currently a staff member or independent contractor.

If you would like a Certificate of Insurance sent to the hospital(s), please indicate and include the address.

_____

_____

Remarks Section: Questions 1 through 19 require additional remarks for all "yes" answers. Please indicate question number(s) referenced.
(Use a separate sheet as 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 rescission 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 5: 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, Inc. 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:_____