Rockbridge Underwriting, An RLI Company
3700 Buffalo Speedway, Suite 300
Houston, TX 77098
(713) 874-8800

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

Renewal Application

Physician Name:				
Business/Entity Name:			Current Policy No.:	
Mailing Address:	City	State	Zip	County
Primary Location Address:	City	State	Zip	County
* Please note the mailing address will be the address listed on the policy.				
Primary Telephone:	Fax:	Home Telephone:	Date of Birth:	
Web Site and E-mail Address:				

What Type of Practice is this:

- ☐ Solo Practice
- ☐ Corporation
- ☐ L.L.C.
- ☐ Partnership (Your % of Ownership?) ______________
- ☐ How many other Physician practice in this entity? __________________
- ☐ Employed Physician (By Whom?) ______________________________
- ☐ Other (Please specify) ______________________________________

Do you have other practice locations? ☐ No ☐ Yes please list:

PRACTICE INFORMATION:

Medical Specialty:	Sub-Specialty:
Average Weekly Patient Encounters:	Average Weekly Practice Hours:

Does your practice include the following:

- ☐ No surgery except incision of boils, cysts, other superficial abscesses or suturing of minor lacerations
- ☐ Assisting in surgery on your own patients — No. Annually ____________________
- ☐ Assisting in surgery on patients other than your own — No. Annually ____________________
- ☐ Minor Surgery — No. Annually ____________________
- ☐ Normal Obstetrical deliveries — No. Annually _______________ — % Cesarean Sections ____________
- ☐ Major Surgery (Includes all procedures done under general, spinal or caudal anesthesia) — No. Annually _____________________

MEDICAL STAFF:

Do you personally employ any of the following support personnel? Include number of employees by category:

☐ Med Lab Tech	☐ LPN/LVN	☐ X-Ray Tech
☐ Pharmacist	☐ RN	☐ Physiotherapist
☐ Scrub Nurse	☐ Optometrist	☐ Psychologist

☐ Med Assistant	☐ Optician	☐ Other:
Indicate the number employed by you or your group for the categories below:		
Midwife	Physician/Surgeon Assistant	Paramedic
CRNA	Nurse Practitioner	Tech
Are any of the above independent contractors?		☐ Yes ☐ No
If independent contractors, do they have individual coverage, independent of you?		☐ Yes ☐ No

CHANGES IN PRACTICE:

HAVE YOU MADE ANY CHANGES WITHIN THE PAST TWELVE (12) MONTHS IN ANY OF THE FOLLOWING: (If yes, provide details on a separate page.)	
Advertising; materials, types, etc.	☐ Yes ☐ No
Board Certification; status change	☐ Yes ☐ No
Business Location(s); additions or deletions	☐ Yes ☐ No
Continuing Medical Education	☐ Yes ☐ No
Contractual Arrangements; additions or deletions	☐ Yes ☐ No
Medical Association/Society Membership; status change	☐ Yes ☐ No
Partnerships/Corporations/Associations; changes, additions or deletions	☐ Yes ☐ No
Procedures Performed; added or discontinued	☐ Yes ☐ No
Specialty; modified, added, etc.	☐ Yes ☐ No
Other, please specify	☐ Yes ☐ No

HAVE YOU MADE ANY CHANGES WITHIN THE PAST TWELVE (12) MONTHS IN ANY OF THE FOLLOWING: (If yes, provide details on a separate page.)	
Has your medical or narcotics license been suspended, denied, revoked or restricted by any state?	☐ Yes ☐ No
Have you been diagnosed with, or treated for, alcoholism, drug addiction or a mental or chronic physical illness?	☐ Yes ☐ No
Have you been indicted or charged in a criminal suit?	☐ Yes ☐ No
Have your hospital privileges been suspended, denied, revoked, restricted or placed in probationary status?	☐ Yes ☐ No
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
Have any claims been made against you, suit papers served upon you, or any other demands for money resulting from a medical incident?	☐ Yes ☐ No
If "Yes", have they been reported to and acknowledged by the Company?	☐ Yes ☐ No
If "Yes", have they been reported to any other current or prior insurance carrier?	☐ Yes ☐ No
Have any prior claims been adjudicated, settled, closed, dismissed or otherwise changed in status?	☐ Yes ☐ No

These warranties are material to the acceptance of coverage by the Company, Mt. Hawley Insurance Company, 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 written to provide 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, and Company Underwriting Criteria.

I hereby expressly consent to any inquiry and investigation through the use of any means legally available to the Company, and I expressly release and discharge the Company, 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.

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

ACKNOWLEDGED AND AGREED:

APPLICANT (Signature Required) DATE:

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier 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.