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

CORPORATE MISCELLANEOUS MEDICAL PROFESSIONAL UNDERWRITING QUESTIONNAIRE AND APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

I. GENERAL INFORMATION

Name of Organization:

Street Address:	City:	State:	Zip Code:	County:

Type of Ownership:	☐ Corporation	☐ Partnership	☐ Sole Proprietorship

Number of years under present ownership _____

Contact Person for Billings:

_____ ( ) _____

Name Title Phone Number

Contact Person for Claims:

_____ ( ) _____

Name Title Phone Number

Corporate Medical Director(s) _____

II. COVERAGE REQUESTED

Effective Date:	Retroactive Date:	Deductible/SIR:
☐ $100,000/$300,000	☐ $200,000/$600,000	☐ $250,000/$750,000
☐ $500,000/$1,000,000	☐ $500,000/$1,500,000	☐ $1,000,000/$3,000,000

Is Prior Acts coverage needed? _____ For Prior Acts coverage, please attach a schedule of physicians and retroactive dates.

III. PROFESSIONAL LIABILITY INSURANCE COVERAGE (for previous three year period).

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability	$	$	$
Deductible or SIR and Amount	☐ Deductible ☐ SIR $	☐ Deductible ☐ SIR $	☐ Deductible ☐ SIR $
Coverage Form	☐ Claims-Made ☐ Occurrence	☐ Claims-Made ☐ Occurrence	☐ Claims-Made ☐ Occurrence
Prior Acts Date			
Policy Period	Fr.: To:	Fr.: To:	Fr.: To:

* If Claims Made, attach copy of policy.

IV. EXPOSURES

a. Fully describe the operations: _____

b. Number of encounters anticipated for the next twelve (12) months: _____

c. Annual gross receipts anticipated for the next twelve (12) months: _____

Provide the following information for the past five years.

Policy Year	Total # of Patient Encounters	Type of Encounter	Total Gross Receipts

V. MEDICAL INDEPENDENT EMPLOYEES/CONTRACTORS

Category

a. MEDICAL SPECIALTY		EMPLOYEES			CONTRACTORS	
		Full Time	Part Time		Full Time	Part Time
Registered Nurses						
Licensed Practical Nurse						
Physician Assistants						
Physicians						
Others (list type)						

b. Are references listed by new applicants checked in writing? ☐ Yes ☐ No

c. Are diplomas, licenses and other credentials for applicants verified prior to employment? ☐ Yes ☐ No

d. Is the initial employment for a specified probationary period? ☐ Yes ☐ No
If yes, what is the probationary period?

e. Are any non-medical employees associated with your organization? ☐ Yes ☐ No
If yes, please describe:

VI. CLAIMS INFORMATION

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No If yes, complete a claims supplement for each claim. Total Number of Claims Open Closed

VII. CONDITIONS OF APPLICATION

By applying for Medical Malpractice Insurance from Mt. Hawley Insurance Company, I hereby:

- consent to inspection by Mt. Hawley Insurance Company or their agents of all documents that may be material to an evaluation of the group's qualifications and competence;
- release from liability Mt. Hawley Insurance Company, their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications;
- release from liability any and all individuals and organizations who provide information to Mt. Hawley Insurance Company or their agents, in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

Date

X
Applicant's Signature

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.