Rockbridge Underwriting, An RLI Company
3700 Buffalo Speedway, Suite 300
Houston, TX 77098
(713) 874-8800
(713) 874-8899 fax

Corporate Locum Tenens Underwriting Questionnaire and Application for Professional Liability Insurance

INTRODUCTION

Please answer all questions. If the information is not known or is to follow, please indicate.
If the information requested is not applicable to your organization, indicate "N/A".

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GENERAL INFORMATION

Name of Organization: _____

Address: _____
Street

_____
City County State Zip Code

Type of ownership: ☐ Corporation ☐ Partnership ☐ Solo Practitioner

Number of years under present ownership _____

Contact Person for Billings:

_____ **( )** _____
Name Title Phone #

Contact Person for Claims:

_____ **( )** _____
Name Title Phone #

Corporate Medical Director: _____
Name

Proposed Inception Date: _____ / _____ / _____

Is Prior Acts coverage needed? ☐ Yes ☐ No **Retro Date:** _____ / _____ / _____

IF "YES", PLEASE COMPLETE THE PRIOR ACTS SUPPLEMENT.

	PER OCCURRENCE	AGGREGATE
Requested Limits of Liability:	$	$
Requested Deductible:	$	$
Requested Self-Insured Retention:	$	$

EXPOSURE BASIS

List below states in which you intend to work and what specialties will be provided.

State and County where Services are Rendered	Specialties and Classes *Please Refer to List Below and specify if no surgery or minor surgery class	Annual Locum Hours OR Days

LOCUM TENEN SPECIALTIES

DESCRIPTION

NO SURGERY OTHER THAN INCISION OF BOILS OR SUTURING OF SKIN. Allergy; Cardiology; Dermatology; ENT; Endocrinology; Family Practice; Gastroenterology; General Practice; Gynecology; Hematology; Internal Medicine; Nephrology; Neurology; Oncology; Ophthalmology; Pathology; Pediatrics; Psychiatrists - no shock Treatment; Pulmonary Disease; Radiology (diagnostic) with no invasive procedures; Rheumatology.

MINOR SURGERY. Dermatology; Diabetes; Endrocrinology; Family Practice; Gastroenterology; General Practice; Gynecology; Hematology (including bone marrow); Internal Medicine; Nephrology; Neurology; Opthalmology; Pathology; Pediatrics; Radiology including invasive procedures.

Neonatology; Ophthalmology including major surgery; Urology including minor surgery; Therapeutic radiology; Surgical Dermatology; Oncology, procedures such as angiography, arteriography, venography with catheterization. Emergency Medicine.

Anesthesiology.

General Surgery; Plastic Surgery; ENT with Plastic Surgery; Surgery; Surgery-gynecology.

Surgery - Orthopedic; Thoracic; Vascular; Traumatic; Cardiac; Cardiovascular.

Obstetrics/Gynecology; Family Practice with Obstetrics; Surgery - Obstetrics.

Physical Therapy; Certified Registered Nurse Anesthetists (C.R.N.A.); Occupational Therapy; Speech and Recreational Assistants.

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EXPOSURE BASIS

Is the adding of additional specialties contemplated during the coming year: ☐ Yes ☐ No

If "YES," please describe _____

Provide the following information for the past five years:

Fiscal Year	Total # of Locum Hours
20___	
20___	
20___	
20___	
20___	

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PROFESSIONAL LIABILITY INSURANCE COVERAGE

Current Professional Liability Insurance:

Present Insurance Carrier: _____

Coverage Type: ☐ Occurrence ☐ Claims Made

IF CLAIMS MADE, ATTACH COPY OF POLICY.

Present Premium: _____

Present Limits of Liability: $ _____ / $ _____

Policy Expiration Date: _____ / _____ / _____

Previous Professional Liability Insurance - past five years:

Policy Year	Insurance Carrier	Policy Limits	Policy Type	SIR/Deductible Amount
20___			☐ Occurrence ☐ Claims Made	
20___			☐ Occurrence ☐ Claims Made	
20___			☐ Occurrence ☐ Claims Made	
20___			☐ Occurrence ☐ Claims Made	
20___			☐ Occurrence ☐ Claims Made	

Has any company refused coverage, cancelled, or refused to renew any insurance?

☐ Yes ☐ No If Yes, please explain: _____

List all claims for the group and all medical professionals for the last five years. Use a separate sheet if necessary, or attach a copy of the loss report.

Physician's Name	Institution / City/State	Allegation	Type of Injury	Date of Treatment / Date of Claim	Status (Event, Claims, Suit)	Amounts Paid to Date	Amounts Reserved to Date	Name of Insurance Carrier
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

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MEDICAL INDEPENDENT CONTRACTORS/EMPLOYEES

MEDICAL SPECIALTY	Number Full Time	Number Part Time
Anesthesiology		
Family Practice		
Emergency Medicine		
Internal Medicine		
Pathology		
Pediatrics		
Psychiatry		
Radiology		
Other		

SURGICAL SPECIALTY	Number Full Time	Number Part Time
General		
Neurosurgery		
OB/GYN		
Oral Surgery		
Ophthalmology		
Orthopedics		
Plastic		
Urology		
Vascular/Thoracic		

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

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

Is the initial employment for a specified probationary period? ☐ Yes ☐ No If 'Yes,' what is the probationary period? _____

Does the organization have a formal physician peer-review process? ☐ Yes ☐ No

Are any non-physician professionals (employees/independent contractors) associated with your organization? ☐ Yes ☐ No If 'Yes,' please describe: _____

Have any of your physicians been involved in an impaired physician program for substance abuse or mental or nervous disorder? ☐ Yes ☐ No If 'Yes,' please attach details.

Have any of your physicians had a license or hospital privileges restricted, suspended or revoked? ☐ Yes ☐ No If 'Yes,' please attach details.

CURRENT PHYSICIAN ROSTER

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
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26. _____
27. _____
28. _____
29. _____
30. _____
31. _____

PRIOR ACTS SUPPLEMENTARY INFORMATION

Name of Group (Insured): _____

Requested Policy Term: _____

PRIOR ACTS COVERAGE IS PROVIDED FOR ALL PHYSICIANS ONLY FOR WORK PERFORMED ON BEHALF OF THE ABOVE NAMED GROUP SUBSEQUENT TO THE RETROACTIVE DATE SHOWN, AND DOES NOT INCLUDE ANY MOONLIGHTING OR WORK PERFORMED OUTSIDE OF THE GROUP CONTRACT. IF COVERAGE FOR WORK OUTSIDE OF THE GROUP CONTRACT IS NEEDED, PLEASE COMPLETE THE FOLLOWING.

Is Prior Acts coverage requested for individual specific physicians for work performed outside of the group? If so, please provide the following:

PHYSICIAN'S NAME	RETROACTIVE DATE	LIMITS DURING RETROACTIVE PERIOD	SPECIALTY	LOCATION

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CONDITIONS OF APPLICATION

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

- consent to the 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 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.

	X
Date	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, or attempt to defraud or lie to us about any matter contained in this application.