Catlin Underwriting Agency U.S., Inc.

Corporate Emergency Room/Ambulatory Care 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"

1.

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 No.

Corporate Person for Claims:

_____ ( )
Name Title Phone No.

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:	$	$

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2. Organizational Locations

Names and addresses of ALL locations, whether insured by Catlin Underwriting Agency U.S., Inc. or not

Location Name of Hospital, Street, City, State	Annual Number of ED Visits / Annual Number of Fast Track Visits	Number ED Hours/Year	Check if Free Standing Clinic	Number Clinic Visits/Year	Number Clinic Hours/Year	Other Types of Organizational Services	Location to be Covered/Retro Date
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

2.

Organizational Locations (cont'd)

Are any of the group's physicians medical directors of any EMS or other organization?
_____YES _____ NO If "YES," please attach list
Is the adding of additional sites contemplated during the coming y **_____ YES _____ NO**
If 'YES", please describe _____

Provide the following information for the past five years:

Fiscal Year	Total of ER Visits	Total No. of Clinic Visits
19___		
19___		
19___		
19___		
19___		

3.

Professional Liability Insurance

Current Professional Liability Insurance:
Present Insurance Carrier: _____
Coverage Type: ___ Occurrence ___ Claims Made
IF CLAIMS MADE, ATTACH COPY OF CURRENT 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/Ded. Amount
19___			___Occurrence/___Claims Made	
19___			___Occurrence/___Claims Made	
19___			___Occurrence/___Claims Made	
19___			___Occurrence/___Claims Made	
19___			___Occurrence/___Claims Made	

Has any company refused coverage, cancelled, or refused to renew any insurance?
___ YES ___ NO If "YES," please explain _____

In the last five years, have any claims or suits for any alleged malpractice ever been brought against the group, any of its employed or contracted physicians or para-professionals (whether or not affiliated with the group at the time of claim/suit)?
___ YES ___ NO

In the last five years, have any incidents occurred involving the group, any of its employed or contracted physicians or paraprofessionals (whether or not affiliated with the group at the time of incident), that could lead to a suit or claim?
___ YES ___ NO

If "YES", to either of the two preceding questions, complete the following page - include all items reported to other carriers.

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List all insurance claims for each physician 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.								

4.

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

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 suspended or revoked, or hospital privileges suspended or revoked? ___ YES ___ NO
If "YES" please attach details.

5.

Current Physician Roster

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____
28. _____
29. _____
30. _____

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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 AT SCHEDULED LOCATIONS SUBSEQUENTLY TO THE RETROACTIVE DATE SHOWN FOR EACH LOCATION, AND DOES NOT INCLUDE ANY MOONLIGHTING OR WORK PERFORMED OUTSIDE OF THE GROUP CONTRACT. IF COVERAGE FOR WORK OUTSIDE OF THE GROUP CONTRACT AT SCHEDULED LOCATIONS IS NEEDED, PLEASE COMPLETE THE FOLLOWING.

Is Prior Acts coverage requested for work performed on behalf of the Group, but at an unscheduled location? If so, please list location and retroactive period to be covered.

LOCATION - CITY/STATE	START DATE	TERMINATION DATE

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

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

6.

Conditions of Application

By applying for Medical Malpractice Insurance from Catlin Underwriting Agency U.S., Inc., I hereby:

1. consent to the inspection by Catlin Underwriting Agency U.S., Inc. or their agents of all documents that may be material to an evaluation of the group's qualifications and competence;

2. release from liability Catlin Underwriting Agency U.S., Inc., 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;

3. release from liability any and all individuals and organizations who provide information to Catlin Underwriting Agency U.S., Inc. 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.