INSPIRIEN

505 Cloverdale Road, Suite 104
Montgomery, AL 36106
Return to: notifications@inspirien.net

Renewal Questionnaire for Professional Liability Insurance for Physicians and Dentists

Section 1 - General Information

If your policy covers more than one physician, each physician must complete a renewal questionnaire.

Named Insured	**Expiring Policy #**
Specialty	**National Provider Number (NPI)**
Legal Name of Organization	

If you own the organization, do you desire separate limits for the organization? Yes No

Have there been any changes in your practice that you need to make us aware of (merger or acquisition activity, change in ownership, changes in services offered, change in staff) that has not been reported to us? Yes No

Do you desire any changes to your coverage that differ from your current policy? Yes No

If yes to any of the above, please explain

_____
_____
_____

Section 2 – Provider Information

Please answer the following questions: Use the space provided to explain any affirmative answers.

How many hours do you practice per week? _____
(Practice hours include patient visits, consultations, hospital rounds, charting, and on call hours involving patient contact)

Do you have a group affiliation, or practice with any other physicians not covered by this policy? Yes No
If yes, list the name(s) of those physicians and name of their professional liability carrier.

_____
_____
_____

Indicate the number of Allied Health employees below sharing in your limit (i.e PA/CRNP/CRNA/CNM/Podiatrist). To have any of these employees covered under a separate limit of liability, please complete the Allied Health Employees Desiring Separate Limits below.

Allied Employees Sharing in Limits:

Classification	# of Employees	# of FTE's (Full Time Equivalents)
Certified Nurse Midwife		
Certified Registered Nurse		
Anesthetists		
Physician's Assistant		
Nurse Practitioner		
Chiropractor		

Allied Employees Desiring Separate Limits:
Allied Health Employees desiring separate limits of $1Million each claim/$3Million aggregate
If separate limits are purchased, a reporting endorsement/tail is required when they leave your employment.

Allied Name	Classification (CNM, CRNA, PA, NP, Podiatrist)	License #	Start Date

Do you staff an Emergency Department? Yes No
If yes, is this required to maintain hospital staff privileges? Yes No
How many hours per month do you practice in the emergency department? _____

Do you provide professional health care services to correction institution inmates (federal or state prisons, county jail, or youth detention centers)? Yes No
If yes, please describe your duties and hours worked?

_____
_____
_____

Do you provide health care services to nursing homes, assisted living, or other convalescent homes? Yes No
If yes, please describe your duties and hours worked?

_____
_____
_____

Do you have professional liability coverage for this exposure? Yes No Carrier: _____

Do you supervise any individuals other than your own employees? Yes No
If yes, provide a detailed explanation of your responsibilities and your relationship to the entity which employes these individuals.

_____
_____
_____

Are you practicing any additional states which have not been previously disclosed to us? Yes No
If yes, list the state and your license number.

State _____ Percentage _____ License Number _____
State _____ Percentage _____ License Number _____
State _____ Percentage _____ License Number _____

	Yes	No
Do you practice or perform consultations, diagnose films/slides or specimens, or perform any other telemedicine activities on any patients that reside outside your primary state of practce which this policy needs to cover?		
Have you been the subject of investigative or disciplinary proceedings or reprimanded by a state medical licensing, government agency, hospital, or professional association?		
Has your state license or narcotic license been surrendered (voluntarily or involuntarily), denied, placed on probation, revoked or suspended?		
Have you been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses?		
Have you failed any medical licensing or specialty organization examination in the past 3 years?		
Have you been named in a claim or suit for professional malpractice, or have any judgements been made against you or any out-of-court settlements made on your behalf that Inspirien is unaware of?		
Have you been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including, but not limited to depression and/or chronic fatigue?		
Do you presently have a medical condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?		
Are your medical license and D.E.A current? If no, please explain. _____ _____ _____		
Has there been any change in your practice, procedures, or profession?		
Are you aware of any incidents, which may result in a malpractice claim or suit being filed?		

Section 3 - Change in Practice

I agree to notify Inspirien of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to a change in specialty, addition or cessation of medical procedures as well as any change in my practice location.

State Disclosure Addendum

Read Carefully Before Signing

The statements in this application, together with any supplemental applications, attachments and any other information submitted to the company in connection with this application will be referred to as the "policy application."

Representations as to accuracy of application, the authority of person signing, and applicant's obligation to supplement information

By signing below, I represent and certify: (I) that the information contained in the policy application is true and accurate; (ii) that I have made all reasonable efforts to investigate the accuracy of the information provided in the policy application and to obtain such information from all persons and entities to be insured by the requested policy as is necessary to provide true and accurate information in the policy application; and (iii) that I am duly authorized to sign this policy application on behalf of all persons and entities to be insured by the requested insurance and that I have carefully read this policy application.

I acknowledge that obtaining the requested insurance, including any renewals of the requested insurance, is conditioned upon providing true and accurate information in this policy application, and any such insurance that may be issued will be based upon the company's reliance on the information provided in the policy application. I also agree and understand that this policy application shall be the basis of the contract should a policy be issued, and that this policy application will be deemed to be attached to and part of such policy and any renewals of such policy, if issued. Further, if any information in this policy application is misleading, incomplete or false, the company may void the insurance issued pursuant to this policy application to the extent permitted by applicable law.

I agree that I will immediately notify the company in writing of any material change in the information provided in this policy application that may occur before the effective date of the requested insurance or before any renewal of the requested insurance. I understand that if I fail to provide such notice, the company may void the insurance issued pursuant to this policy application or any renewal of the requested insurance. I understand that, to the extent permitted by applicable law (and except as may be prohibited under Montana and/or Oregon law), the company may in its sole discretion modify or withdraw any quotation or agreement to bind insurance in the event of any material change in the information provided in this policy application.

No Obligation to Issue or Purchase Insurance
I understand that the policy application is not a binder of insurance. Accepting the policy application does not bind the company to issue, or me to purchase, the requested insurance regardless of whether I have made payment, in whole or in part, for the requested insurance or whether the company has deposited such payment. I understand that the requested insurance shall not be effective until I have paid a deposit to the company in the amount invoiced by the company, regardless of whether or not a policy or any renewals of such policy have been issued.

Authorization to Obtain Information
The company is hereby authorized to obtain full information from any liability insurer, healthcare insurer, hospital, healthcare provider, medical association or society, board of medical examiners, governmental agency, attorney or other person or entity concerning: (I) any medical malpractice claim, suit, licensing board proceeding, credentialing proceeding, disciplinary action or any other civil or criminal action asserted against or relating to the professional conduct of any person or entity to be covered by the requested insurance; (ii) the qualifications of any person or entity to be covered by the requested insurance to perform professional healthcare services; and (iii) such other information which, in the sole judgment of the company, may have a bearing on whether to issue the requested insurance. I agree to hold harmless any person or entity providing such information to the company and the company, its directors, officers, employees, and agents from any liability arising out of the disclosure of such information, including any liability arising out of errors and omissions in the information disclosed.

Alabama, Arkansas, Indiana, Kentucky, Minnesota, New Mexico, New York, Rhode Island, Tennessee, Texas, West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties which may include voiding of the policy if allowed by state law.

California Applicants: For your protection California law requires the following to appear on this form: any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides

false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulated Agencies.

District of Columbia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Applicants: Per 24-A M.R.S.A. 2186(3), it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

New Jersey Applicants: Any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Applicants: WARNING: any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. For an insurer to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the insured, the insurer must show that the misinformation is material to the insurance policy, that the insurer relied on the misinformation and that the misinformation was provided fraudulently.

Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Virginia Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Washington Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature of Applicant	Title
Printed Name of Applicant	Date
Signature of Producer (signature is required for N.H. producers only)	Date
Printed Name of Producers	