INSPIRIEN INSURANCE COMPANY
P.O. Box 211359
Montgomery, Al 36121-1359
334-271-5515 / Fax: 334-270-831

RENEWAL QUESTIONNAIRE FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS (HOSPITALS)
CLAIMS MADE

Hospital_____ Percentage of admission_____

Physician's Name_____ Date of Birth _____

Address_____

Telephone Number_____

On a separate sheet of paper, please explain any affirmative answers (other than current Medical Licensure) to the following questions

1. **In the past year have you**:

(a)	Been the subject of investigative or disciplinary proceedings or reprimand by a government agency, hospital or professional association?	☐Yes	☐No
(b)	Has your state license or narcotic license been surrendered (voluntarily or involuntarily), denied, revoked or suspended?	☐Yes	☐No
(c)	Been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses.	☐Yes	☐No
(d)	Failed any medical licensing or specialty organization examination?	☐Yes	☐No
(e)	Been named in a claim or suit for professional malpractice?	☐Yes	☐No
(f)	Had any judgments made against you or any out-of-court settlements made in your behalf?	☐Yes	☐No
(g)	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?	☐Yes	☐No
(h)	Have you had or do you presently have any chronic or life-threatening illness?	☐Yes	☐No

2. Is your medical license and D.E.A current? ☐Yes ☐No

3. Has there been any change in your practice, procedures or profession during the past year? ☐Yes ☐No
If yes, explain on a separate sheet of paper.

4. What is the name and version of your EHR (Electronic Healthcare Records) software? ☐Yes ☐No
Please provide a current copy of your EHR contract. You may mark out the cost.

5. Are you aware of any incidents, which may result in a malpractice claim or suit being filed ☐Yes ☐No
If yes, please provide a brief description on a separate piece of paper.

Signing this application does not bind Coastal Insurance Company, Inc. (Coastal) to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information or attempt to defraud or lie to Coastal about any matter contained in this application, then coverage provided by virtue of this application may be void.

Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

I, the undersigned, have provided Coastal information in their application in order for Coastal to evaluate my insurability under their policy of insurance.

Therefore, I hereby authorize all persons, firms, corporations, including but not limited to, prior liability carrier, hospitals and their officers, directors, medical staff and employees, medical association, medical society, the State Board of Medical Examiners for any state in which I have practiced and any other entity, either public or private, to provide Coastal with any information, whether written or otherwise. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to Coastal. I consent to Coastal to use photocopies of this authorization for release of information. Each photocopy is to be considered an original copy.

APPLICANT DATE

Submit via Email If Signed Electronically

Print