MedChoice Renewal Application

MedChoice RISK RETENTION GROUP

Policy Number TBD

As of: Date

PLEASE UPDATE ANY INFORMATION THAT IS INCORRECT ON THE REVERSE PAGE OR LEFT BLANK

First Name	Middle Name	Last Name	Degree

Address	City	State	Zip

Phone	Fax	E-Mail	Office Contact

Corporate Name	Weekly Patients	Weekly Hours

Current Limits	Effective Date	Retro. Date	Specialty

Additional Insured : Yes ☐ No ☐ ☐ check if changes are on the reversed page

PLEASE EXPLAIN ANY "YES" RESPONSE, OR PROVIDE ANY REQUIRED EXPLANATION OR DETAILS ON SUPPLEMENTARY PAGES AND ATTACH TO THIS RENEWAL APPLICATION.

1. Have there been any major changes to your practice within the last 12 months? These changes include: procedures performed, scope of practice, new specialty or subspecialty certifications, merchandise sold, drug study participation or receiving treatment for alcohol or drug abuse. ☐ Yes ☐ No
2. Are you aware of any potentially compensible events resulting from patient care? ☐ Yes ☐ No
3. Have there been any incidents to patients from services rendered by you or anyone in your office that resulted in death, permanent damage/disability, or any other injury/bad outcome? ☐ Yes ☐ No
4. Has any patient or family of a patient expressed disappointment or discontent with services or procedures provided by your or anyone in your office? ☐ Yes ☐ No
5. Have you received an unexpected request for patient records from an attorney who you were previously not aware of, or are you aware of any adverse outcomes which might have given rise to this request? ☐ Yes ☐ No
6. Have you been subject to any civil or criminal investigation or had any disciplinary action filed against you which has been initiated by any patient, their families, an employee/ex-employee or regulatory authorities? ☐ Yes ☐ No
7. Have any awards or settlements been paid on your behalf for claims which were previously open with a prior insurance carrier? ☐ Yes ☐ No
8. Did you function as a Medical Director for any facility? If yes, name of the facility and length of time you have been there. Do you admit patients for the above facility? ☐ Yes ☐ No
9. Have you served as an expert witness or have you been deposed as an expert in any case of medical malpractice? If so, please supply copies of your deposition or testimony if available. ☐ Yes ☐ No
10. Do/Did you employ, subcontract with, supervise, or sponsor any physicians, nurse practitioners, physician assistant or other mid-level providers? If yes, please list names, describe their specialties, if they have their own professional liability insurance policy, and the nature of the professional relationship. ☐ Yes ☐ No

I hereby represent and warrant the truth of all statements and reasons mentioned herein and that I have not withheld any information that islikely to influence the judgment of MedChoice Risk Retention Group in considering this application for professional liability insurance. Iagree to notify MedChoice Risk Retention Group promptly of any change in the information contained in this application. I further agreeto be bound by the underwriting guidelines of MedChoice Risk Retention Group.

Signature: _____ Date: _____

11. Please indicate below your best estimate of the number of the following procedures you expect to perform, or in which you will participate, in the next year, beginning with the date of your renewal coverage:

Abortions - first trimester:
_____ Hospital
_____ Clinic
_____ Office
Abortions - after first trimester:
_____ Hospital
_____ Clinic
_____ Office
_____ Acupuncture
_____ Adenoidectomies
_____ "Alternative Medicine" or "complementary medicine" procedures (as viewed by most physicians)
Please describe: _____
Anesthesia - obstetrical:
_____ General
_____ Spinal
_____ Epidural
Anesthesia - non-obstetrical:
_____ General
_____ Spinal
_____ Epidural
_____ Anesthesia (other) - Please describe: _____
_____ Angiographies
_____ Angioplasty
_____ Arteriorgraphies
_____ Assisting in major surgery - own patients
_____ Assisting in major surgery - other than own patients
_____ Breast implants
_____ Breast reductions
Catheterizations:
_____ Cardiac
_____ Arterial
_____ Other - Please describe: _____
_____ Chelation therapy
_____ Chemabrasion
_____ Chemical Peels
_____ Chemotherapy
_____ Colonoscopies
_____ Cosmetic implantation or injection of silicone or other materials - Please describe:
_____
_____ Cryosurgery - Please describe: _____
_____ D & C's
Deliveries:
_____ Vaginal
_____ Cesarean
_____ Vaginal after Cesarean
_____ Discograms
_____ Electromyography
_____ Endoscopy (other than proctoscopy or sigmoidoscopy) - Please describe: _____
_____ Eyeliner pigmentation
_____ Fracture reductions - closed
_____ Fracture reductions - open
_____ Hair transplants, or other hair growing or replacement techniques

☐ I DO NONE OF THESE PROCEDURES

Hemorrhoidectomies:
_____ Internal
_____ External
_____ Herniorrhaphies
Laparoscopy:
_____ Diagnostic - Please describe: _____
_____ Surgical - Please describe: _____
_____ Laser Surgery - Please indicate type of surgery: _____
_____ Liposuction
_____ Lumbar punctures
_____ Manipulation therapy
_____ Myelography
_____ Needle aspriations
_____ Needle biopsies
_____ Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts - Please indicate type of surgery: _____
_____ Pacemaker insertion
_____ Pain management - Please indicate type: _____
_____ Pre-natal care
_____ Radial keratotomies
_____ Radiation - diagnostic
_____ Radiation - therapeutic
_____ Sclerotherapy (choose one) <1mm >1mm
_____ Shock therapy
_____ Spinal Surgery
_____ Tattoo removal
_____ Thoracentesis
_____ Tonsillectomies
_____ Total joint replacements
_____ Tubal ligations
_____ Vasectomies
_____ Venography
_____ Weight control by means other than diet or exercise - Please describe: _____
_____ Any other procedure you reasonably believe will be of interest to a medical professional liability insurer - Please describe: _____
☐ I DO NONE OF THESE PROCEDURES

12. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of major surgery:

_____ Abdominal
_____ Bariatric
_____ Cardiac
_____ Colon/rectal
_____ General
_____ Gynecologic
_____ Hand
_____ Head and Neck
_____ Neurosurgical
_____ Obstetrical
_____ Opthamalogical
_____ Orthopedic - including spinal surgery
_____ Orthopedic - without spinal surgery
_____ Plastic - cosmetic
_____ Plastic - reconstructive
_____ Thoracic
_____ Traumatic
_____ Urologic
_____ Vascular
☐ I DO NONE OF THESE PROCEDURES