



MedChoice Renewal Application

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		City	State Zip
<input type="text"/>		<input type="text"/>	<input type="text"/>
Phone	Fax	E-Mail	Office Contact
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Corporate Name		Weekly Patients	Weekly Hours
<input type="text"/>		<input type="text"/>	<input type="text"/>
Current Limits	Effective Date	Retro. Date	Specialty
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

- 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
- Are you aware of any potentially compensible events resulting from patient care? Yes No
- 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
- 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
- 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
- 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
- Have any awards or settlements been paid on your behalf for claims which were previously open with a prior insurance carrier? Yes No
- 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
- 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
- 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 is likely to influence the judgment of MedChoice Risk Retention Group in considering this application for professional liability insurance. I agree to notify MedChoice Risk Retention Group promptly of any change in the information contained in this application. I further agree to 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

_____ Arteriographies

_____ 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 aspirations

_____ 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 keratotomy

_____ 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	_____ Ophthalmological
_____ Bariatric	_____ Orthopedic - including spinal surgery
_____ Cardiac	_____ Orthopedic - without spinal surgery
_____ Colon/rectal	_____ Plastic - cosmetic
_____ General	_____ Plastic - reconstructive
_____ Gynecologic	_____ Thoracic
_____ Hand	_____ Traumatic
_____ Head and Neck	_____ Urologic
_____ Neurosurgical	_____ Vascular
_____ Obstetrical	<input type="checkbox"/> I DO NONE OF THESE PROCEDURES