



# 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