Catlin Underwriting Agency, U.S., Inc.
1330 Post Oak Blvd. Ste 2325
Houston, TX 77056

CORPORATE EMERGENCY ROOM / AMBULATORY CARE MEDICAL PROFESSIONAL UNDERWRITING QUESTIONNAIRE AND APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

I. IDENTIFYING INFORMATION

Name of Organization as it should appear in the Declarations:

Street Address:	City:	State:	Zip Code:	County:

Type of Ownership:	☐ Corporation	☐ Partnership	☐ Sole Practitioner	☐ Other, please describe

Number of years under present ownership ______________________________

Contact Person for Billings:

( )

Name Title Phone Number

Contact Person for Claims:

( )

Name Title Phone Number

Corporate Medical Director(s) ______________________________
Corporate Risk Manager(s)

II. COVERAGE REQUESTED

Effective Date:	Retroactive Date:	Deductible/SIR:
☐ $100,000/$300,000	☐ $200,000/$600,000	☐ $250,000/$750,000
☐ $500,000/$1,000,000	☐ $500,000/$1,500,000	☐ $1,000,000/$3,000,000

Is Prior Acts coverage needed? ______ For Prior Acts coverage, please attach a schedule of physicians and retroactive dates.

Do any of the physicians maintain their own limits of Insurance? __________ If yes, please provide listing and limit amounts.

III. PROFESSIONAL LIABILITY INSURANCE COVERAGE (for previous five year period).

Insurance Company	Policy Number	Policy Period	Limits of Liability	Deductible or SIR and Amount	Coverage Form
Carrier: Premium:		Effective: Expiration:	$	☐ Deductible ☐ SIR $	☐ Claims-Made ☐ Occurrence Retro Date:
Carrier: Premium:		Effective: Expiration:	$	☐ Deductible ☐ SIR $	☐ Claims-Made ☐ Occurrence Retro Date:
Carrier: Premium:		Effective: Expiration:	$	☐ Deductible ☐ SIR $	☐ Claims-Made ☐ Occurrence Retro Date:
Carrier: Premium:		Effective: Expiration:	$	☐ Deductible ☐ SIR $	☐ Claims-Made ☐ Occurrence Retro Date:
Carrier: Premium:		Effective: Expiration:	$	☐ Deductible ☐ SIR $	☐ Claims-Made ☐ Occurrence Retro Date:

* If Claims Made, attach copy of policy.

Has any company refused coverage, cancelled, or refused to renew any insurance? If "Yes," please explain: _____	☐ Yes	☐ No
In the last ten years, have any claims or suits for any alleged malpractice ever been brought against the group, any of its employed or contracted physicians or paraprofessionals (whether or not affiliated with the group at the time of claim/suit)?	☐ Yes	☐ No
In the last ten years, have any incidents occurred involving the group, any of its employed or contracted physicians or paraprofessionals (whether or not affiliated with the group at the time of incident), that could lead to a suit or claim?	☐ Yes	☐ No
If "Yes," to either of the two preceding questions, please complete the following - include all items reported to other carriers.		

CLAIMS HISTORY - Please complete a claim supplement for each claim.

Physician's Name	Location City, State	Type	Status	Allegation	Amounts Paid to Date	Amounts Reserved to Date
1.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		
2.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		
3.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		
4.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		
5.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		
6.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		
7.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		
8.		☐ Claim ☐ Incident ☐ Suit	☐ Closed ☐ Open ☐ Pending		Expense: Indemnity:	Expense: Indemnity:
Insurance Carrier:				Date of Treatment: Date of Claim:		

IV. ORGANIZATIONAL LOCATIONS

CURRENT YEAR: 20__

Names and addresses of ALL locations, whether to be insured by Catlin Underwriting Agency U.S., Inc. or not

Location: Name of Hospital Street, City, State	Annual Number of ED visits / Annual Number of Fast Track Visits	Number ED Hours/Year	Free-Standing Clinic?	Number Clinic Visits/Year	Number Clinic Hours/Year	Other Types of Organizational Services	Location to be covered? / Retroactive Date
1.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
2.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
3.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
4.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
5.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
6.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
7.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
8.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
9.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
10.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
11.			☐ Yes ☐ No				☐ Yes ☐ No Retro:
12.			☐ Yes ☐ No				☐ Yes ☐ No Retro:

Are any of the group's physicians medical directors of any EMS or other organization? ☐ Yes ☐ No
If "Yes," please attach a list.

Is the adding of additional sites contemplated during the coming year? ☐ Yes ☐ No
If "Yes," please describe: _____

Please provide the following information for the past five years:

Fiscal Year	Total Number of ER Visits	Total Number of Fast Track Visits	Total Number of Clinic Visits
20__			
20__			
20__			
20__			
20__			

V. MEDICAL INDEPENDENT EMPLOYED/CONTRACTED PROFESSIONALS

Category

a. MEDICAL SPECIALTY	NUMBER EMPLOYED		NUMBER CONTRACTED	
	Full Time	Part Time	Full Time	Part Time
CRNA				
Registered Nurses / LPN				
Registered Nurse Practitioner				
Physician Assistants				
Physicians:				
- Anesthesiology				
- Family Practice				
- Emergency Medicine				
- Internal Medicine				
- Pathology				
- Pediatrics				
- Psychiatry				
- Radiology				
Others (list type)				
SURGICAL SPECIALTY	NUMBER EMPLOYED		NUMBER CONTRACTED	
	Full Time	Part Time	Full Time	Part Time
General				
Neurosurgery				
OB/GYN				
Oral Surgery				
Ophthalmology				
Orthopedics				
Plastic				
Urology				
Vascular/Thoracic				

b. Are references listed by new applicants checked in writing? ☐ Yes ☐ No

c. Are diplomas, licenses and other credentials for applicants verified prior to employment? ☐ Yes ☐ No

d. Is the initial employment for a specified probationary period? ☐ Yes ☐ No
If yes, what is the probationary period? _____

_____

_____

e. Does the organization have a formal physician peer-review process? ☐ Yes ☐ No

f. Are any non-medical employees associated with your organization? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

_____

g. Have any physicians been involved in an impaired physician program for substance abuse or mental or nervous disorder? ☐ Yes ☐ No
If "Yes," please attach details.

h. Have any of your physicians had a license suspended or revoked, or hospital privileges suspended or revoked? ☐ Yes ☐ No
If "Yes," please attach details.

i. **Current Physician Roster**

	Name	Specialty	Retroactive Date
1.			
2.			
3.			
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VI. PRIOR ACTS SUPPLEMENTARY INFORMATION

Name of Group (Insured): _____

Requested Policy Term: _____

PRIOR ACTS COVERAGE IS PROVIDED FOR ALL PHYSICIANS ONLY FOR WORK PERFORMED ON BEHALF OF THE ABOVE NAMED GROUP AT SCHEDULED LOCATIONS SUBSEQUENT TO THE RETROACTIVE DATE SHOWN FOR EACH LOCATION, AND DOES NOT INCLUDE ANY MOONLIGHTING OR WORK PERFORMED OUTSIDE OF THE GROUP CONTRACT. IF COVERAGE FOR WORK OUTSIDE OF THE GROUP CONTRACT AT SCHEDULED LOCATIONS IS NEEDED, PLEASE COMPLETE THE FOLLOWING:

Is Prior Acts coverage requested for work performed on behalf of the Group, but at an unscheduled location? If so, please list each location and retroactive period to be covered:

LOCATION - CITY / STATE	RETROACTIVE DATE	TERMINATION DATE

Is Prior Acts coverage requested for individual specific physicians for work performed outside of the group contracts? If so, please provide the following:

PHYSICIAN'S NAME	RETROACTIVE DATE	LIMITS DURING RETROACTIVE PERIOD	SPECIALTY	LOCATION

VII. CONDITIONS OF APPLICATION

By applying for Medical Malpractice Insurance from Catlin Underwriting Agency, U.S., Inc. , I hereby:

- consent to inspection by Catlin Underwriting Agency, U.S., Inc. or their agents of all documents that may be material to an evaluation of the group's qualifications and competence;
- release from liability Catlin Underwriting Agency, U.S., Inc., their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications;
- release from liability any and all individuals and organizations who provide information to Catlin Underwriting Agency US, Inc., in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

Date	X Applicant's Signature

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

FRAUD NOTICE

Arkansas	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.
Colorado	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 for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Louisiana	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	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	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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 civil fines and criminal penalties.
New York	**All commercial insurance forms, except as provided for automobile insurance:** 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **Automobile insurance forms** Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation. **Fire Insurance:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.
Ohio	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	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.
Pennsylvania	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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Auto:** Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.
Puerto Rico	Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars ($5,000), not to exceed ten thousands dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Rhode Island	**Property Insurance, Real Or Personal:** The insurance application form shall indicate the existence of a criminal penalty for failure to disclose a conviction of arson.
Tennessee	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. **Workers Compensation:** It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.
Virginia	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.
West Virginia	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.