P.O. Box 211359
Montgomery, AL 36121-1359
Return to: notifications@inspirien.net

Renewal Questionnaire for Professional Liability Insurance for Physicians and Dentists

If your policy covers more than one physician, each physician must complete a renewal questionnaire.

Named Insured _____ Expiring Policy # _____

Specialty _____

National Provider Number (NPI) _____

Legal Name of Organization _____

If you own the organization, do you desire separate limits? _____

Have there been any changes in your practice that you need to make us aware of? (merger or acquisition activity, change in ownership, change in services offered, change in staffing that has not been reported to us)

Do you desire any changes to your coverage that differ from your current policy? (Please explain)

Please answer the following questions: (Please use space provided to explain any affirmative answers)

1. How many hours do you practice per week? _____

   (Practice hours include patient visits, consultations, hospital rounds, charting, and on call hours involving patient contact)

2. Do you have a group affiliation, or practice with any other physicians not covered by this policy? ☐Yes ☐No

   If YES, list the name(s) of those physicians and name of their professional liability carrier.

3. Do you employ any allied health employee(s) (i.e. PA/CRNP/CRNA/CNM/Chiropractors/Podiatrist) that you have not reported to us and desire coverage for?

   ☐Yes ☐No If YES, list their name, professional classification and employment date below.

   Name _____ Certification/Classification _____ Employment Date _____

   Name _____ Certification/Classification _____ Employment Date _____

   Name _____ Certification/Classification _____ Employment Date _____

4. Do you staff an Emergency Department? ☐Yes ☐No

   If YES, is this required to maintain hospital staff privileges? _____

   How many Hours per month do you practice in the emergency department? _____

5. Do you provide professional health care services to correction institution inmates (federal or state prisons, county jails, or youth detention centers)?

   ☐Yes ☐No If YES, please describe your duties and hours worked?

6. Do you provide health care services to nursing homes, assisted living, or other convalescent home? ☐Yes ☐No

If YES, please describe your duties and list name of facility.

Do you have professional liability coverage for this exposure? ☐Yes ☐No With Whom? _____

7. Do you supervise any individuals other than your own employees? ☐Yes ☐No

If YES, provide a detailed explanation of your responsibilities and your relationship to the entity which employs these individuals

8. Are you practicing any additional states which have not been previously disclosed to us? If so, list the state and your license number.

State _____ Percentage _____ License Number _____

State _____ Percentage _____ License Number _____

State _____ Percentage _____ License Number _____

State _____ Percentage _____ License Number _____

9. Do you practice or perform consultations, diagnose films/slides or specimens, or perform any other telemedicine activities on any patients that reside outside your primary state of practice which this policy needs to cover? ☐Yes ☐No

10. Have you been the subject of investigative or disciplinary proceedings or reprimanded by a state medical licensing, government agency, hospital or professional association? ☐Yes ☐No

11. Has your state license or narcotic license been surrendered (voluntarily or involuntarily), denied, placed on probation, revoked or suspended? ☐Yes ☐No

12. Have you been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No

13. Have you failed any medical licensing or specialty organization examination in the past 3 years? ☐Yes ☐No

14. Have you been named in a claim or suit for professional malpractice, or have any judgements been made against you or any out-of-court settlements made on your behalf that Inspirien Insurance Company is unaware of? ☐Yes ☐No

15. 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

16. Do you presently have any chronic or life-threatening illness which affects your ability to practice medicine? ☐Yes ☐No

17. Is your medical license and D.E.A current? (Explanation only needed if answer is NO) ☐Yes ☐No

18. Has there been any change in your practice, procedures, or profession? ☐Yes ☐No

19. Are you aware of any incidents, which may result in a malpractice claim or suit being filed? ☐Yes ☐No

Change in Practice

I agree to notify Inspirien of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to a change in specialty, addition or cessation of medical procedures as well as any change in my practice location.

Authorization for Release of Information

I hereby authorize all persons, firms, corporations, including but not limited to, prior liability carriers, hospitals and their officers, directors, medical staff and employees, medical associations, medical societies, the State Board of Medical Examiners for any states in which I have practiced and any other entities, either public or private, to provide Inspirien 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 Inspirien. I consent to Inspirien to use photocopies of this authorization for release of information. Each photocopy is to be considered an original copy.

Signing this Renewal Questionnaire does not bind Inspirien Insurance Company (Inspirien) 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. Should the undersigned withhold important information, supply misleading information or attempt to defraud or lie to Inspirien 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.

Date _____ (x) _____

(Applicant Signature)

_____

(Printed Name)