

**PROTECTING  
PHYSICIANS  
SINCE 1976**

**RENEWAL  
INSURANCE  
APPLICATION**

For Physicians and Surgeons

**INSTRUCTIONS**

Please print responses in ink, and answer all questions in full. If a question does not apply to your practice, state "none" or "NA" (Not Applicable). Please indicate any additional responses in the Remarks Section on page 8.

**GENERAL INFORMATION**

1. First Name  Middle Name  Last Name  Suffix  Title

Jr./Sr./III

2. Policy Number

**ADDRESSES**

3. Primary Practice E-mail Address

May we use this e-mail address to send you TDC information?  Yes  No

4. Home Address

Street  Apt.

City  State  Zip  -

Phone

5. Practice Addresses

List all current office or clinic practice locations in this section. Include all locations whether or not TDC insurance is desired at that location. If additional space is required to show more than three practice locations, please photocopy this page.

- Facility Codes. Please indicate all that apply at each location.
- |                           |                             |
|---------------------------|-----------------------------|
| 01: Outpatient Office     | 06: Urgent Care Center      |
| 02: Nursing Home          | 07: Emergi-Center           |
| 03: Correctional Facility | 08: Commercial Laboratory   |
| 04: Surgery Center        | 09: Other (please identify) |
| 05: Abortion Clinic       |                             |

A. Name of Location

Facility Code  % of Practice

Street  Ste.

City  State  Zip  -

County

Phone  Fax

Do you own , rent , or lease  this location? If other, please explain on page 8.

Is TDC insurance desired for this practice location?  Yes  No

If no, what is the name of your insurance carrier? (If self-insured, please indicate.)

B. Name of Location

Facility Code  % of Practice

Street  Ste.

City  State  Zip  -

County

Phone  Fax

Do you own , rent , or lease  this location? If other, please explain on page 8.

Is TDC insurance desired for this practice location?  Yes  No

If no, what is the name of your insurance carrier? (If self-insured, please indicate.)

C. Name of Location

Facility Code  % of Practice

Street  Ste.

City  State  Zip  -

County

Phone  Fax

Do you own , rent , or lease  this location? If other, please explain on page 8.

Is TDC insurance desired for this practice location?  Yes  No

If no, what is the name of your insurance carrier? (If self-insured, please indicate.)

6. Billing Address Other Than Primary Practice

If you require that your premium billing be sent to an address other than your primary practice address, please indicate.

Street/P.O. Box  Bldg./Suite

City  State  Zip  -

## PRACTICE INFORMATION

7. Please indicate the number of hours you work per week for each of the following. (Include only work covered by The Doctors Company.)

A. Number of hours per week for office and clinical practice (direct patient care, consultation, administrative activities, etc.):

B. Number of hours per week for being on call:

C. Number of hours per week for hospital rounds:

D. Number of hours per week for scheduled surgery:

E. If you are an anesthesiologist, indicate your number of billable hours per week:

8. A. What is your average weekly patient load?

B. How many surgical procedures do you perform per week?

## SPECIALTY

9. Primary Specialty

Name of Specialty

% of Practice  Are you board certified?  Yes  No If yes, date

Mo./Day/Yr.

Name of Board

**TYPE OF PRACTICE**

10. Secondary Specialty  
Name of Specialty   
% of Practice  Are you board certified?  Yes  No If yes, date   
Mo./Day/Yr.  
Name of Board

11. A. What is your practice structure?  
 Partnership  Individual  
 DBA or fictitious name  Solo medical corporation  
 Other medical corporation

**Please provide a copy of your current letterhead.**

B. Give name of entity and list partners' or members' names:

12. Do you employ any physicians besides yourself in your practice?  
 Yes  No If yes, list below with details.

13. Do you independently contract with any entities or physicians?  
 Yes  No If yes, list below with details.

If you are an independent contractor, please complete the following statement:  
My association with

Group/Physician Name  
is that of an independent contractor, and the relationship conforms to the guidelines of the Internal Revenue Service.  
   
Signature Date  
   
Group/Physician Name Carrier

**A current Declarations Page or Certificate of Insurance for the above group/physician must be attached.**

14. Are you employed by any physicians or entities?  
 Yes  No If yes, list below with details.  
If yes to #12, 13, or 14, indicate the names and addresses of all such groups, clinics, professional corporations, partnerships, commercial enterprises, government, or public entities. Show the date of affiliation, status of employment, hours worked (weekly), number of physicians at each of the entities, percentage of your practice this represents, and if malpractice insurance is provided for this work. If there is more than one facility, please explain in the Remarks Section, page 8.

**ANCILLARY  
PERSONNEL**

15. Will you be performing activities which will be covered by another professional liability policy?  Yes  No  
If yes, please provide proof of coverage, including name and address of entity.

16. If you or your entity employs or contracts for the services of any health care personnel in the following categories indicated by \*, a separate application form must be submitted for each.

A. Physician's Assistants\*

Number Employed  Number Contracted  Insurer, If Any

B. Nurse Practitioners\*

Number Employed  Number Contracted  Insurer, If Any

C. Certified Registered Nurse Anesthetists\*

Number Employed  Number Contracted  Insurer, If Any

D. Certified Nurse Midwife\*

Number Employed  Number Contracted  Insurer, If Any

E. Optometrists\*

Number Employed  Number Contracted  Insurer, If Any

F. List other paramedical personnel, including nurses, technicians, technologists, physical therapists, etc.

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Number Employed  Number Contracted  Insurer, If Any

**ADVERTISING**

17. Do you advertise your medical practice? (If yes, provide copies of advertisements that you are currently using or have placed in periodicals, yellow pages, on flyers, handouts, etc. Also, provide a copy of the script if you are using voice or film media.)

Yes  No

18. Do you have a Web site address?  Yes  No If yes, specify name.

**TELEMEDICINE**

19. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunications, video, or information systems?

Yes  No If yes, list below with details.

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**TEACHING/  
MEDICAL  
DIRECTORSHIP  
RESPONSIBILITIES**

20. Do you have any teaching responsibilities?  Yes  No  
**If yes, complete the following questions. Use the Remarks Section if needed.**
- A. Name and location of institution:
- B. Does the institution provide you with coverage for these responsibilities?  Yes  No
- C. What percentage of your weekly time is devoted to clinical teaching?  %

21. Do you have any medical director responsibilities?  Yes  No  
**If yes, complete the following questions. Use the Remarks Section if needed.**
- A. Name and location of entity:
- B. Does the entity provide you with coverage for:  
 Your administrative responsibilities?  Yes  No    Your direct patient care?  Yes  No  
 If no to either of the above, please provide proof of medical professional liability insurance for the entity.

**EMERGENCY  
ROOM  
RESPONSIBILITIES**

22. Do you staff an Emergency Room for purposes other than to maintain hospital privileges?  Yes  No  
 If yes, please describe location, hours worked, relationships, etc.
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**STAFF  
PRIVILEGES**

23. List all facilities, including nonhospital facilities, where you have staff privileges. List principal location first. Use the Remarks Section, page 8, to list additional facilities. Please list the name of the facilities.
- | Facility             | City                 | State                | Department           | % of Practice        |
|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

24. Do you treat or review treatment of prison inmates?  Yes  No    If yes, please explain on page 8.
25. Do you perform medical legal evaluations?  Yes  No  
 If yes, with whom?   
 What percentage of your practice does this entail?  %

**CHANGES IN PRACTICE**

26. Have your practice specialties/procedures, etc., changed in the past five years?  Yes  No  
If yes, please explain how the specialties/procedures, etc., have changed and give the dates of changes.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PROCEDURES**

27. Do you practice in any office surgical facility in which IV analgesia or general anesthetics are administered?

Yes  No If yes, list facilities: \_\_\_\_\_

If yes to question #27, is the office certified by AAAASF or AAAHC?  Yes  No

If yes, please submit a copy of current certification; if no, please complete a Supplemental Surgery Suite Questionnaire.

28. Do you or any of your staff perform elective cosmetic procedures?  Yes  No  
If yes, please specify the procedure(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. Do you practice obstetrics? (Obstetrics include prenatal care.)  Yes  No

Do you perform deliveries other than in a hospital?  Yes  No  
If yes, specify facility:

\_\_\_\_\_

Do you perform obstetrical home deliveries?  Yes  No

30. Do you perform abortions?  Yes  No

If yes,

First Trimester?  Yes  No

Second Trimester?  Yes  No

Third Trimester?  Yes  No

List facilities where you perform abortions:

\_\_\_\_\_

Number of abortions per month: \_\_\_\_\_

Do you receive referrals?  Yes  No

If yes, from whom? \_\_\_\_\_

31. Do you perform sex-reassignment surgery?  Yes  No

Weight-control Surgery?  Yes  No

## MISCELLANEOUS

If you answer yes to any of the following questions, please give full details in the Remarks Section, page 8. Include dates and copies of related documents. If previously reported, please give an update on the current status.

32. Do you treat or consult on patients in any sovereign nation or territory, other than the United States, such as Native American or Alaskan Native lands?

Yes  No

If yes, list the location  and % of practice  %

33. Are you now being—or have you ever been—treated for alcoholism, narcotics addiction, or mental illness?

Yes  No  Previously Reported

(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution. If previously reported to the Exchange, please provide an update on your current status only.)

34. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?

Yes  No  Previously Reported

(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution. If previously reported to the Exchange, please provide an update on your current status only.)

35. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible and/or surcharge assessed against you? **NOTE: MISSOURI APPLICANTS DO NOT RESPOND.**

Yes  No  Previously Reported

36. Have you ever been investigated by any state licensing board, narcotics board, DEA, or other governmental or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended, or limited in any way?

Yes  No  Previously Reported

(If yes, please provide copies of complaint and disposition documents if not previously provided. If under investigation, please provide current status on your letterhead.)

37. Has any hospital ever restricted or revoked your privileges or invoked probation for any cause?

Yes  No  Previously Reported

38. Have you ever been indicted and/or convicted of a crime other than minor traffic violations?

Yes  No  Previously Reported

39. Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)?

Yes  No  Previously Reported

40. Has a claim or suit for any alleged malpractice been brought against you or settled on your behalf that has not already been reported to the Exchange? If yes, complete the Claim Information Form attached to this application.

Yes  No



**Notice to District of Columbia Applicants:** 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.

**Notice to Florida Applicants:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Notice to Kentucky Applicants:** 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.

**Notice to Louisiana Applicants:** 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.

**Notice to New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Notice to New York Applicants:** 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 \$5,000 (five thousand dollars) and the stated value of the claim for each such violation.

**Notice to Ohio Applicants:** Any person who, with intent to defraud or knowing that he or she 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.

**Notice to Pennsylvania Applicants:** 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.

**Notice to Tennessee Applicants:** 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.

**Notice to Virginia Applicants:** 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, denial of insurance benefits, and civil damages.

**SIGNATURE  
REQUIRED**



Applicant Signature

Date

**CLAIM  
INFORMATION  
FORM**

Photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.

1. Name of Patient  2. Age  3. Sex

4. Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon, etc.)

5. Allegation

6. Date of Incident    7. Report Date     
Month Day Year Month Day Year

8. Location

9. Insurance Carrier

10. Other Defendants

11. Present Status  Open Claim    Loss of \$      Settlement  
 Closed Claim    Date Closed      Judgment  
 Dismissed

12. Condition and diagnosis at time of incident:

13. Dates and description of professional services rendered:

14. Condition of patient subsequent to professional services (and dates of follow-up visits) if known:

**SIGNATURE  
REQUIRED**



I hereby declare the above information is complete and true to the best of my knowledge and belief.  
Signature  Date

**PROXY**

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them, my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company, an Interinsurance Exchange.

This proxy is solicited on behalf of the management of the Exchange and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

**This proxy, unless revoked or replaced by substitution, shall remain in force for five years from the date stated below.**

**You may revoke this proxy by giving the Exchange written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.**

**The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.**

**SIGNATURE  
REQUIRED**



Signature

Type or Print Name

Street

City  State  Zip  -

Date

(If undated, the date of receipt will be inserted by The Doctors Company. Address any question you may have to the Secretary of the Exchange.)