

# PROFESSIONAL UNDERWRITERS LIABILITY INSURANCE COMPANY

## Professional Liability Policy Renewal Application

Broker:  
The Doctors Insurance Agency  
5151 Shoreham Place Ste.180  
San Diego, CA, 92122

Renewal of Policy Number: \_\_\_\_\_

**All information below must be completed and all questions answered "Yes" or "No". Please correct any incorrect data.**

Applicant's Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Principal Office Address \_\_\_\_\_ Office Phone & Office FAX \_\_\_\_\_

Other Office Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Address \_\_\_\_\_

Medical Specialty \_\_\_\_\_ Renewal Date \_\_\_\_\_

**Practice History:** (Please explain all "Yes" answers in the "Remarks Section" on reverse.)

1. Since your last application to us, have you been investigated or are you currently being investigated by a State Board of Medical Examiners Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency or has your license to practice medicine or your permit to prescribe or dispense drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?  YES  NO
2. Since your last application to us, have your privileges at any hospital or other institution been reduced, denied, revoked, restricted or suspended?  YES  NO
3. Since your last application to us, have there been any changes in your medical specialty, practice or procedures performed?  YES  NO
4. Have you formed a new corporation? If yes, name of corporation \_\_\_\_\_
5. Are you American Board Certified? If yes, specialty and date \_\_\_\_\_
6. Do you have any new professional associates (contracting, partners, etc.)?  YES  NO
7. Do you employ any medical personnel? If so, please list them on reverse.  YES  NO
8. What is your average weekly patient load? \_\_\_\_\_
9. Since your last application to us, have there been any judgments, settlements, or dismissals of any previously reported claims, regardless of insurance carrier?  YES  NO
10. Since your last application to us, have you become aware of any claims or suits; or facts or circumstances, medical incidents, records requests, or letters of intent that may give rise to a claim or suit? **If YES, complete a Claims Information Form for each and indicate what carrier, if any, the claim was reported to.**  YES  NO
11. Since your last application to us, have you been diagnosed with or treated for any physical or mental conditions or impairments that might affect your ability to practice medicine?  YES  NO

12. Do you provide services at a nursing home, skilled nursing facility or assisted living center? \_\_\_\_\_. If "YES", percent of patients: \_\_\_\_\_. If "YES", do you treat other than your own patients at the facility? \_\_\_\_\_.
13. Does your practice include the use of Botox (Botulinum Type A)?: \_\_\_\_\_. If "YES", provide the number of annual treatments: \_\_\_\_\_. What procedures/purpose?: \_\_\_\_\_. Indicate location(s) where Botox services are being rendered: \_\_\_\_\_. Indicate who in your office renders the treatment: \_\_\_\_\_.
14. List hospitals at which you are currently a staff member. If you would like a Certificate of Insurance sent to the hospital(s), please include the address.

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**Remarks Section:** (Please indicate question number(s) referenced. Use a separate sheet if necessary.)

Question Number	Remarks
_____	_____
_____	_____
_____	_____

**AGREEMENTS:**

- I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not withheld any information which is calculated to influence the judgment of the Company in considering this application for renewal of my professional liability insurance. Erroneous and/or material misrepresentation will cause immediate rescission of my insurance coverage.
- I understand that the policy being applied for does not cover liability of others which I may have assumed under any contract or agreement.
- I understand that completing a Claims Information Form with this application does not fulfill my obligation to provide notice of Claims, Suits or Incidents as required by the policy. I understand that I must abide by Section IX. POLICY CONDITIONS, Paragraph C. CLAIMS AND DUTY TO COOPERATE in order to properly report a claim to the Company.
- I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter and insurance agent to furnish any information concerning me or my medical practice that the company may request.
- Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

This application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature on the form does not bind the applicant or the Company to issue coverage. No renewal coverage exists until a deposit premium is paid to the Company, Broker or Agent.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND RELEASE OF LIABILITY  
TO PROVIDE VERIFICATION OF COVERAGE AND CLAIMS HISTORY**

I hereby consent to and authorize the release to any Hospital, PPO, IPA, HMO, Credentialing Agency, etc., by any representative of the PULIC Insurance Services, Inc., Professional Underwriters Liability Insurance Company, and/or The Doctors Company, An Interinsurance Exchange, information and documents that may be relevant to a verification of my professional liability insurance and/or claims history. I agree that any person or organization furnishing information pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information. This release is submitted as part of my application and will remain in effect until revoked by me in writing.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PULIC Insurance Services, Inc.  
12121 Wilshire Boulevard, Suite 601  
Los Angeles, California 90025