Professional Solutions Physicians Program
Claims Made Professional Liability Coverage
2008 Renewal Questionnaire

Please print Insureds Name:_____________________________
Please print Insureds Policy Number:______________________________

Please answer all questions. If your answer to any question is "NONE" or "NOT APPLICABLE," please state N/A.

1. Has there been a change to your practice location (s) in the past year? **Yes** / **No** (circle one)

   ⇨ If "Yes," for each location change, please indicate the % of practice, the office address, including State County and Zip Code, on a separate sheet of paper.

2. Total number of hours you work on average per week: ____________

   ⇨ If you now work less than 20 hours per week on average, when did you first reduce your practice hours? ___/____/____

   Practice hours defined as:
   - Hospital rounds,
   - Charting and patient planning,
   - On call hours involving patient contact, whether direct or by telephone,
   - Consultations with other physicians, and
   - Patient visits/consultations

3. Have you added any of the following mid-level ancillary employees in the past year? **Yes** / **No** (circle one)

   ⇨ If yes, please indicate the number of each and date employed:

Position	Count of each	Date(s) 1st Employed
Physician Assistant	______	________________
Nurse Practitioner	______	________________
Surgical Assistant	______	________________
Nurse Anesthetist	______	________________
Psychologist	______	________________
Other (Please identify below :)	______	________________

____

4. Have you completed a loss prevention program in the past year? **Yes** / **No** (circle one)

   ⇨ If yes, please list program and date(s) of attendance: ____

   ____

5. Have you participated in any CME during the past year? **Yes** / **No** (circle one)

6. Have there been any changes in your practice, specialty, or Board Certification in the past year? **Yes** / **No** (circle one)

   ⇨ If yes, please provide full details on a separate sheet of paper

7. Do you utilize an Electronic Medical Record (EMR) system? **Yes** / **No** (circle one)

   ⇨ If yes, for how long? ____________

   ⇨ If you are in a group practice, do all members of the group utilize the EMR system? **Yes** / **No** (circle one)

   ⇨ If no, please explain:

   ____

   ____

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8. Please explain any "Yes" answers to the following questions on a separate sheet of paper and provide any applicable board transcripts or other pertinent information.

   a. In the past year, has any hospital denied, restricted, suspended, or revoked your privileges; have you voluntarily surrendered your privileges; or probation been invoked? **Yes** / **No** (circle one)

   b. In the past year, has your narcotic or medical license been suspended, placed on probation, restricted, revoked, or voluntarily surrendered? **Yes** / **No** (circle one)

   c. In the past year, have you been asked to participate in or have you volunteered to participate in an impaired physician program? **Yes** / **No** (circle one)

   ⇨ If "Yes," please attach a copy of your recovery plan document.

   d. In the past year, have you been the subject of disciplinary proceedings; reprimanded by a governmental agency; convicted of a crime, or currently under investigation for a crime other than a traffic offense? **Yes** / **No** (circle one)

   e. In the past year, have any claims or suits been made or brought against you, or do you have knowledge of any incident that might be made against you that might give rise to a claim that you have not yet reported to the PSIC Claims Department? **Yes** / **No** (circle one)

   ⇨ If "Yes," please complete a "PSIC Claim Information Form" for each claim or suit.

   f. In the past year, have any previously reported/open claims with a prior carrier had a change in status to closed or settled on your behalf by any prior carrier(s)? **Yes** / **No** (circle one)

   ⇨ If yes, please provide an updated loss run to reflect the out come, including any indemnity paid on your behalf.

PLEASE READ, SIGN AND DATE

I agree to notify the Company of any change in my practice of medicine within thirty-(30)-days of its occurrence, including but not limited to the following:

A. A change in specialty or medical procedures performed
B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
C. Investigation, restriction, suspension or surrender of any state, medical, DEA license or Hospital privileges;
D. Any physical or mental condition, illness or defect, including treatment for alcohol or Substance abuse not previously disclosed to the Company in writing;
E. Conviction, plea, or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, and OUI) other than minor traffic offenses.

I hereby acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

Failure to notify the Company of such changes could require retroactive upward premium adjustment or, in the event of a claim, could result in denial of liability.

GENERAL FRAUD WARNING - Any person is guilty of insurance fraud who, with intent to defraud or knowingly facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement.

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete, and accurate, that I have not willfully concealed or misrepresented any material fact of circumstance concerning this insurance of the subject thereof.

X______________________________ X __________ X________________________________ X __________
Signature of Insured Physician Date Signature of Agent Date

Professional SOLUTIONS INSURANCE COMPANY

Please print Insureds Name:____________________________
Please print Insureds Policy Number:____________________________

PSIC CLAIM INFORMATION FORM

1. Name of Applicant: ____

2. Patient's Name: ____

3. Date of Incident from which claim or suit resulted or is likely to result: ______________________________

4. Date claim made against you: ____

5. Allegations made against you: ____

____

____

6. Explain, in detail, the specifics of the incident that led to the claim: _________________________________

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____

7. Present status or disposition of claim including amount reserved or amount of settlement or judgment, if any: ____

8. State, County and Court claim filed in: ____

   ____

9. What insurance company was involved? ____

10. Name of doctors, hospitals, institutions or any other professionals, if any, involved in the claims or suit:

   ____

   ____

X _________________________________ X _____________
Signature of Insured Physician Date

Please photocopy this form as necessary for each claim or incident.