

Renewal Questionnaire

Dear Doctor,

In order to update our records and assure that you are receiving the appropriate coverage that you require, and in accordance with the terms of your policy, **you are required to provide the information requested below and return this form to our office within twenty (20) working days.** If you prefer to fill out a Renewal Application, please contact us and one will be forwarded to you. Failure to return this information within the required time period may result in premium revisions beyond those identified in your renewal statement.

All pages of this form must be signed and returned whether or not there have been any changes to your practice since your last Application.

I. PRACTICE CHANGES

Please mark an "X" on the line next to the appropriate statement and follow the instructions. You must select one of the two statements below.

- () Since my last Pennsylvania PRI Application or Renewal Application, there have been no changes to my practice (including office address, mailing address, procedures, treatments/services provided, hours practicing per week, etc).

If you marked the above statement, please skip questions #1-9 below and proceed to questions #10-14 (must be completed).

- () Since my last Pennsylvania PRI Application or Renewal Application, my practice has changed as indicated below:

If you marked the above statement you must complete questions #1-14 beginning on page 2 below. Mark an "X" next to all that apply and use the space provided to supply details of those changes. If additional space is needed, please attach an additional page.

1. (___) My primary office address has changed as follows:

2. (___) I have added the following additional practice locations (including private practice, clinics, nursing homes, hospitals where you have privileges):

3. (___) My home address has changed as follows:

4. (___) My mailing address has changed as follows:

5. (___) I have **added** the following procedures / treatments / services to my practice:

6. (___) I have **removed** the following procedures / treatments / services from my practice:

7. (___) The total hours I am working per week have changed as follows:

(If you work at multiple locations, please list the hours per week at each address)

8. (___) My specialty has changed as follows:

9. (___) I participate in the following experimental, alternative, or investigative procedures:

10. Governmental Action

a. Since your last application, has any governmental agency **ever** investigated, suspended, revoked, or taken any other action against either your narcotic license or your license to practice? *(If YES, explain)*

Yes No

b. Since your last application, have you been convicted of a crime? *(If YES, explain)*

Yes No

11. Hospital Privileges

Have your privileges at any hospital or other institution been reduced, revoked, restricted, or suspended since your last application with this company? *(If YES, explain)*

Yes No

12. Health

Have you had any health problems, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty since your last application with this company? *(If YES, explain)*

Yes No

II. LOSS FREE DISCOUNT

To qualify or continue to receive an optional Loss Free Discount you must represent and warrant to Pennsylvania PRI that no professional liability claims/ incidents have had a **payment** to a claimant made by you or on your behalf within five (5) years prior to your policy effective or renewal date by signing below. This discount depends on the date of payment and not the date of the claim/incident, or the date the incident/claim was reported.

Representation of No Paid Losses: By signing in the space below, I represent and warrant that, after conducting a good faith investigation into the facts attested to herein, no medical professional liability claims/incidents stemming from my medical practice have been paid by me or on my behalf to a claimant in the last:

(___) 5-9 years

(___) 10+ years

(___) I do not qualify for the Loss Free Discount

I understand the above information is material to Pennsylvania PRI's decision to renew my policy and provide me a Loss Free Discount, and that a misrepresentation by me constitutes a criminal fraudulent insurance act that may subject me to criminal and civil penalties.

Full Name: _____

Signature: _____

Date: _____

Pennsylvania PRI may also, in its sole discretion and at its cost, require you to provide a "Response to Self-Query" from the National Practitioner Data Bank (NPDB) dated within the past six (6) months. You can access this information via their website at <http://www.npdb-hipdb.com/>. If you currently have a Loss Free Discount it will be renewed automatically. **The to Self-Query" must be received by Pennsylvania PRI within 30 days of the date requested or the Loss Free Discount will be removed and you will be invoiced the additional premium.**

III. ATTESTATION

I hereby represent that the information provided in this Policy Renewal Questionnaire is true and correct to the best of my knowledge, and that I have not misrepresented or withheld any information that may influence Pennsylvania PRI's judgment in considering the Renewal Questionnaire for professional liability 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 subjects such person to criminal and civil penalties.

Printed Name:

Policy Number:

E-Mail Address:

Signature:

Date: _____

Producer Affirmation: by my signature, I hereby represent that the applicant has granted me full authority to complete and/or submit this application on their behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that the applicant understands and agrees that such representation is binding upon him or her, even though I am completing and/or submitting the application on their behalf. I further acknowledge that any material misrepresentation or omission made on this application may result in the termination of my broker agreement.

PRODUCER SIGNATURE: _____ Date: _____

We must receive all pages of this form within twenty (20) business days. For your convenience you can either mail this completed form to Pennsylvania PRI, 1800 Northern Blvd., Roslyn, NY 11576 or fax it to 516-684-2324. Thank you in advance for your attention to this matter. If you have any questions, please feel free to call your broker or Pennsylvania PRI directly at 888-771-4762.