



# APPLICATION FOR PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY INSURANCE



**PROFESSIONAL LIABILITY  
INSURANCE SERVICES, INC.**

T: 1-800-713-9473, 770-427-9577

F: 770-427-5218

W: www.pliswholesale.com

E: info@pliswholesale.com

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

## I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: \_\_\_\_\_  
(ii) Professional Degree: \_\_\_\_\_
- (b) Principal practice address: \_\_\_\_\_  

(Street)
(County)

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(City)
(State)
(Zip)
- (c) Secondary practice locations: \_\_\_\_\_  


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- (d) (i) Phone: \_\_\_\_\_ (ii) Fax: \_\_\_\_\_  
(iii) E-Mail Address: \_\_\_\_\_ (iv) Website Address: \_\_\_\_\_
- (e) (i) Date of Birth (MM/DD/YYYY): \_\_\_\_\_ (ii) Place of Birth: \_\_\_\_\_
- (e) (i) Social Security No.: \_\_\_\_\_ (ii) Federal Tax ID Number: \_\_\_\_\_
2. Are you a U.S. citizen? ..... [ ] Yes [ ] No  
If No, what is your status in the U.S. and current citizenship? \_\_\_\_\_
3. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)\*  
[ ] professional corporation\* [ ] professional association\*  
[ ] limited liability company\* [ ] partnership\*  
[ ] employee of \_\_\_\_\_ [ ] independent contractor of \_\_\_\_\_  
[ ] other \_\_\_\_\_  
\* Specify name of entity: \_\_\_\_\_
- (b) Do you want coverage for the entity named Item 3(a) above? ..... [ ] Yes [ ] No
- (c) Attach a copy of your letterhead.
- (d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all physicians practicing under the entity name in Item 3(a) above.  
\_\_\_\_\_  
\_\_\_\_\_
4. Do you practice with any physician not named in Item 3.(d) above? ..... [ ] Yes [ ] No  
If Yes, provide the name of each physician and the practice relationship. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Are you currently in active military service? ..... [ ] Yes [ ] No

6. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. Federal DEA License No. and status: \_\_\_\_\_

8. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

<u>Name</u>	<u>City</u>	<u>State</u>	<u>Percentage of Work</u>	<u>Type of Privileges</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9. Are you currently a hospital chief of staff or head of any hospital department? ..... [ ] Yes [ ] No  
If Yes, describe. \_\_\_\_\_

10. Do you or the entity firm named in Item 3(a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgicenter, urgent care center other facility where medical services are customarily provided? ..... [ ] Yes [ ] No  
If Yes, provide a detailed explanation specifically including the name, location, size, and number of beds. \_\_\_\_\_

11. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No  
If Yes,  
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... [ ] Yes [ ] No  
(ii) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_  
Our Business Associate Agreement is available at [www.shand.com](http://www.shand.com) or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

**II. EDUCATION AND TRAINING**

1. (a) Provide your medical or surgical specialty: \_\_\_\_\_  
(b) Do you limit your practice to the specialty stated in item (a) above? ..... [ ] Yes [ ] No  
(c) Do you have a subspecialty?..... [ ] Yes [ ] No  
If Yes, describe. \_\_\_\_\_

2. Are you American Board certified? ..... [ ] Yes [ ] No  
If Yes, provide the following: Medical specialty in which you are certified: \_\_\_\_\_  
Date of certification: \_\_\_\_\_ Any recertification date(s): \_\_\_\_\_  
If No, do you plan on taking the Board examination? ..... [ ] Yes [ ] No

3. Provide the following information:

	<u>Name of Institution</u>	<u>City</u>	<u>State</u>	<u>Date Completed</u>
Medical School	_____	_____	_____	_____
PGY-1/Internship	_____	_____	_____	_____
Residency – Specialty: _____	_____	_____	_____	_____
Residency – Specialty: _____	_____	_____	_____	_____
Fellowship – Specialty: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

4. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates?..... [ ] Yes [ ] No  
If Yes, provide the following: year of certification: \_\_\_\_\_ describe your medical degree: \_\_\_\_\_

5. Provide a detailed summary of where you have practiced your profession since completing your training:  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Are you a member of any professional societies? ..... [ ] Yes [ ] No  
 If Yes, provide information regarding your membership(s). \_\_\_\_\_
7. How many hours of continuing medical education have you take within each of the last two (2) years? \_\_\_\_\_

**III. SCOPE OF PRACTICE**

1. (a) Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia?..... [ ] Yes [ ] No  
 If Yes, complete 1.(b) below.
- (b) If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: **H** = Hospital **O** = Office **S** = Surgi-center of other

	<u>Location</u>		<u>Location</u>
<input type="checkbox"/> Abortions - 1st Trimester	_____	<input type="checkbox"/> Hysterectomies	_____
<input type="checkbox"/> Abortions - 2nd/3rd Trimester	_____	<input type="checkbox"/> Laser skin resurfacing	_____
<input type="checkbox"/> Acupuncture	_____	<input type="checkbox"/> Laser Surgery (describe)_____	_____
<input type="checkbox"/> Adenoidectomy/Tonsillectomy	_____	<input type="checkbox"/> Lymphangiography	_____
Anesthesia – Non-obstetrical:		<input type="checkbox"/> Minimally invasive surgery (describe)	_____
<input type="checkbox"/> General	_____	<input type="checkbox"/> Moh's micrographic surgery	_____
<input type="checkbox"/> Spinal	_____	<input type="checkbox"/> Myelography	_____
<input type="checkbox"/> Epidural	_____	<input type="checkbox"/> Needle biopsies (describe)_____	_____
Anesthesia – Obstetrical:		Obstetrics:	
<input type="checkbox"/> General	_____	<input type="checkbox"/> Prenatal care	_____
<input type="checkbox"/> Spinal	_____	<input type="checkbox"/> Normal deliveries - annual no._____	_____
<input type="checkbox"/> Epidural	_____	<input type="checkbox"/> Caesarean sections - annual no._____	_____
<input type="checkbox"/> Anesthesia – Other (describe)	_____	<input type="checkbox"/> VBAC deliveries – annual no._____	_____
<input type="checkbox"/> Angiography	_____	<input type="checkbox"/> Open Reduction of Fractures	_____
<input type="checkbox"/> Angioplasty	_____	<input type="checkbox"/> Pain Management (describe)	_____
<input type="checkbox"/> Anti-aging procedures – other than use of human growth hormone (describe)_____	_____	Plastic – Cosmetic Procedures:	
<input type="checkbox"/> Arteriography	_____	<input type="checkbox"/> Blepharoplasty	_____
<input type="checkbox"/> Assisting in Surgery – on own patients or the patients of others	_____	<input type="checkbox"/> Collagen injections	_____
<input type="checkbox"/> Breast Implants	_____	<input type="checkbox"/> Botox injections	_____
<input type="checkbox"/> Breast Reductions	_____	<input type="checkbox"/> Liposuction under 3500 cc's volume	_____
<input type="checkbox"/> Catheterization - other than umbilical cord, urethral or arterial line in a peripheral vessel	_____	<input type="checkbox"/> Liposuction 3500 cc's or more volume	_____
<input type="checkbox"/> Cosmetic implantation or injection of silicone or other material	_____	<input type="checkbox"/> Phalloplasty or penile implant	_____
<input type="checkbox"/> Cryosurgery - other than on benign or pre-malignant dermatological lesions	_____	<input type="checkbox"/> Rhinoplasty	_____
<input type="checkbox"/> Chelation Therapy	_____	<input type="checkbox"/> Silicone implants	_____
<input type="checkbox"/> Dermabrasion/Chemical Peels	_____	<input type="checkbox"/> Silicone injections	_____
<input type="checkbox"/> Dilation & Curettage	_____	<input type="checkbox"/> Other plastic – cosmetic procedures (describe) _____	_____
<input type="checkbox"/> Discograms	_____	<input type="checkbox"/> Pneumoencephalography	_____
<input type="checkbox"/> Electroconvulsive Therapy	_____	<input type="checkbox"/> Prolotherapy/proliferative therapy	_____
<input type="checkbox"/> Endoscopic procedures	_____	<input type="checkbox"/> Radiation Therapy	_____
<input type="checkbox"/> Hair Transplants or Suturing of Hairpieces	_____	<input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	_____
<input type="checkbox"/> Hyperbaric Medicine	_____	<input type="checkbox"/> Refractive surgery: LASIK, PRK, AK, PTK, ICR	_____
		<input type="checkbox"/> Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy)	_____
		<input type="checkbox"/> Trans Myocardial Laser procedures	_____

2. (a) Do you perform surgery for obesity? ..... [ ] Yes [ ] No  
If Yes, complete 2.(b) below.
- (b) If you perform any of the following procedures, check all that apply and provide the number of procedures performed:
- Roux-en-Y:
- \_\_\_ Laparoscopic:  
No. performed in past 12 months: \_\_\_\_\_  
No. you expect to perform in next 12 months: \_\_\_\_\_
- \_\_\_ Open:  
No. performed in past 12 months: \_\_\_\_\_  
No. you expect to perform in next 12 months: \_\_\_\_\_
- Banding:
- \_\_\_ Laparoscopic:  
No. performed in past 12 months: \_\_\_\_\_  
No. you expect to perform in next 12 months: \_\_\_\_\_
- \_\_\_ Open:  
No. performed in past 12 months: \_\_\_\_\_  
No. you expect to perform in next 12 months: \_\_\_\_\_
- Gastric Restriction, Other (describe) \_\_\_\_\_:  
No. performed in past 12 months: \_\_\_\_\_  
No. you expect to perform in next 12 months: \_\_\_\_\_
3. Is general anesthesia administered for any of the procedures identified in 1.(b) or 2. above? ..... [ ] Yes [ ] No  
If Yes, is anesthesia administered by:
- (a) you? ..... [ ] Yes [ ] No
- (b) an Anesthesiologist? ..... [ ] Yes [ ] No
- (c) a Certified Registered Nurse Anesthetist (CRNA)? ..... [ ] Yes [ ] No  
If Yes, is the CRNA directed by or responsible to an Anesthesiologist? ..... [ ] Yes [ ] No  
If No, explain the type of surgery and percentage of your surgeries or average number of such cases per month.
- 
- (d) Are Harvard Standards for the administration of all anesthesia adhered to? ..... [ ] Yes [ ] No
4. (a) Do you perform any surgery in your office? ..... [ ] Yes [ ] No  
If Yes, answer the following:
- (i) Describe each procedure not already identified above in 1(b) or 2 above: \_\_\_\_\_  
\_\_\_\_\_
- (ii) Is your surgical suite certified? ..... [ ] Yes [ ] No  
If Yes, provide the name of the certification body. \_\_\_\_\_
- (b) Do you perform any surgery in other non-hospital facilities? ..... [ ] Yes [ ] No  
If Yes, answer the following:
- (i) Describe each procedure not already identified above in 1(b) or 2 above: \_\_\_\_\_  
\_\_\_\_\_
- (ii) Name each facility: \_\_\_\_\_  
\_\_\_\_\_
5. With the exception of surgery for obesity, does your practice include weight reduction or control by other than diet or exercise? ..... [ ] Yes [ ] No  
If Yes, answer the following:
- (a) Percentage of your patients that are weight control patients: \_\_\_\_\_
- (b) Do you dispense any drugs? ..... [ ] Yes [ ] No  
If Yes, provide the name(s) of the drug(s) dispensed. \_\_\_\_\_

- (c) Do you use injections for weight control? ..... [ ] Yes [ ] No  
If Yes, provide the name(s) of the drugs injected. \_\_\_\_\_
6. Do you perform any hospital emergency room care? ..... [ ] Yes [ ] No  
If Yes, is this solely a requirement for active admitting privileges? ..... [ ] Yes [ ] No  
If No, provide a detailed description including the approximate number of hours per month spent in emergency room care. \_\_\_\_\_
- 
7. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? ..... [ ] Yes [ ] No  
If Yes, provide the following:
- (a) Identify all states in which such patients reside: \_\_\_\_\_
- (b) What percentage of your total practice is involved in such activities? \_\_\_\_\_
8. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? ..... [ ] Yes [ ] No  
If Yes, identify all states in which such patients reside. \_\_\_\_\_
9. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? ..... [ ] Yes [ ] No  
If Yes, do you follow FDA-approved protocols? ..... [ ] Yes [ ] No  
If Yes, describe. \_\_\_\_\_
- 
- (b) Are you a Principal Investigator for any clinical trial? ..... [ ] Yes [ ] No
10. (a) Indicate the number of professional employees in your practice for each of the following: (If none, check here [ ] )
- |                                    |                     |                          |                         |
|------------------------------------|---------------------|--------------------------|-------------------------|
| ___ Physicians other than yourself | ___ Podiatrists     | ___ Chiropractors        | ___ Optometrists        |
| ___ Physician's Assistants*        | ___ Nurses          | ___ Nurse Practitioners* | ___ Nurse Anesthetists* |
| ___ Surgeon's Assistants*          | ___ Nurse Midwives* | ___ Psychologists        |                         |
| ___ Other (describe) _____         |                     |                          |                         |
- \*Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.
- (b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ..... [ ] Yes [ ] No  
If No, provide a detailed explanation on a separate page.
11. (a) Average weekly patient load: \_\_\_\_\_ (b) Number of patients annually: \_\_\_\_\_
12. Average number of hours you practice each week: \_\_\_\_\_
13. What is your approximate gross annual income from your practice? (Check one.)
- |                            |   |
|----------------------------|---|
| ___ Less than \$50,000     | ___ \$50,000 to \$99,999                  |
| ___ \$100,000 to \$149,999 | ___ \$150,000 to \$199,999                |
| ___ \$200,000 to \$499,999 | ___ \$500,000 or more (estimate) \$ _____ |
14. Do you supervise anyone other than your own employees? ..... [ ] Yes [ ] No  
If Yes, indicate by profession the number of individuals you supervise:
- |                                    |                            |                            |                        |
|------------------------------------|----------------------------|----------------------------|------------------------|
| ___ Physicians other than yourself | ___ Podiatrists            | ___ Chiropractors          | ___ Optometrists       |
| ___ Physician's Assistants         | ___ Nurses                 | ___ Nurse Practitioners    | ___ Nurse Anesthetists |
| ___ Surgeon's Assistants           | ___ Nurse Midwives         | ___ Psychologists          |                        |
| ___ Radiology Technicians          | ___ Laboratory Technicians | ___ Other (describe) _____ |                        |
- Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. \_\_\_\_\_
-

15. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

16. Do you currently participate in any state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? ..... [ ] Yes [ ] No

17. Do you anticipate any changes in your practice in the next year? ..... [ ] Yes [ ] No  
If Yes, attach a detailed explanation.

**IV. AFFILIATIONS**

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section I. 3(a) above? ..... [ ] Yes [ ] No  
If Yes, provide a detailed explanation including a description of your responsibilities. \_\_\_\_\_

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section I. 3(a) above? ..... [ ] Yes [ ] No  
If Yes, provide a detailed explanation including a description of your responsibilities. \_\_\_\_\_

If Yes, does any contract contain a hold harmless agreement? ..... [ ] Yes [ ] No  
If Yes, attach a copy of the contract.

3. Are you in the employ of or under contract to any governmental entity? ..... [ ] Yes [ ] No  
If Yes, provide a detailed explanation including a description of your responsibilities. \_\_\_\_\_

4. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? ..... [ ] Yes [ ] No  
If Yes, attach a copy of all advertisements.

5. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? ..... [ ] Yes [ ] No  
If Yes, attach a copy of the advertisement or applicable website address.

6. Are you the Medical Director of a nursing home, clinic, commercial enterprise or any other organization? ..... [ ] Yes [ ] No  
If Yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position. \_\_\_\_\_

7. Do you have any administrative or teaching responsibilities? ..... [ ] Yes [ ] No  
If Yes, provide the following and attach a copy of any contract or agreement:

(a) Name of entity and location: \_\_\_\_\_  
Your title \_\_\_\_\_

(b) Does the entity provide you coverage for:  
(i) Your administrative responsibilities? ..... [ ] Yes [ ] No  
(ii) Your direct patient care? ..... [ ] Yes [ ] No

8. Do you work for any locum tenens companies? ..... [ ] Yes [ ] No  
 If Yes, provide the following :
- (a) Name of each company that places you in locum positions: \_\_\_\_\_
- (b) Are you an [ ] Employee or [ ] Independent Contractor?
- (c) Number of hours each month in which you work in locum positions: \_\_\_\_\_
- (d) Does each company provide you with Professional Liability Insurance for locum positions?..... [ ] Yes [ ] No  
 If Yes, attach a copy of your Certificates of Insurance.
9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location? ..... [ ] Yes [ ] No  
 If Yes, provide details. \_\_\_\_\_
10. Are you engaged in or planning to engage in any "moonlighting" activities? ..... [ ] Yes [ ] No  
 If Yes, do you want coverage for your "moonlighting" activities? ..... [ ] Yes [ ] No  
 If Yes, describe the activities. \_\_\_\_\_

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**V. CLAIMS AND HISTORY**

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1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance?..... [ ] Yes [ ] No  
 If Yes, how many? \_\_\_\_\_ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? ..... [ ] Yes [ ] No  
 If Yes, how many? \_\_\_\_\_ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?.. [ ] Yes [ ] No  
 If Yes, how many? \_\_\_\_\_ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges?..... [ ] Yes [ ] No
5. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?..... [ ] Yes [ ] No
6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? ..... [ ] Yes [ ] No
7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? ..... [ ] Yes [ ] No
8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders?..... [ ] Yes [ ] No
9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty?..... [ ] Yes [ ] No

**Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.**

**NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY**

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

Shand Morahan & Company, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which Shand Morahan & Company, Inc. receives notice is on file with Shand Morahan & Company, Inc. and is considered physically attached to and part of the of the policy if issued. Shand Morahan & Company, Inc. and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Shand Morahan & Company, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

**WARRANTY**

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc. or the Company, Ten Parkway North, Deerfield, Illinois 60015.

Must be signed by the Applicant within 60 days of the proposed effective date.

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

<p><b>Notice to Applicants:</b> 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 the person to criminal and civil penalties.</p>
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**ADDITIONAL EXPLANATIONS**

\_\_\_\_\_  
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## **BROKER RISK SUMMARY (Medical Malpractice and Specified Medical)**

### ACCOUNT NAME:

Address  
City, State, Zip  
States of Licensure  
New or Renewal for Shand

### DESCRIPTION OF SERVICES:

(Include management experience & staffing)

### CURRENT INSURANCE PROGRAM:

Name of Carrier: \_\_\_\_\_

Limits: \_\_\_\_\_ Deductible: \_\_\_\_\_ Premium: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Retro Date: \_\_\_\_\_

### LOSS EXPERIENCE:

(7-10 years currently valued loss information)

### RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:

(Including Credentialing/hiring protocols)

### DATE QUOTE NEEDED: