



Professional Liability Renewal Application

All information below must be completed and all questions answered "Yes" or "No". Please provide any extra explanations on a separate page.

Primary Insured Policy Number Renewal Date

Principal Office Address Office Phone Number

Medical Specialty Sub Specialty Email Address

Renewal Questions: (Please explain all "Yes" answers on separate page)

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| 1. During the current policy period are you aware of any potential administrative issues with regard to your license to practice medicine or prescribed drugs? | Yes | No |
| 2. During the current policy period have there been any changes in your hospital privileges? | Yes | No |
| 3. During the current policy period have any previously open claims closed? | Yes | No |
| 4. During the current policy period has your office location changed? | Yes | No |
| 5. During the current policy period has there been a change in the number of hours you work? | Yes | No |
| 6. During the current policy period has there been any changes to the paraprofessionals you employed? | Yes | No |
| 7. During the current policy period have you added procedures you previously did not perform? | Yes | No |
| 8. During the current policy period have any medical incidents or unhappy patients contacted you directly or through an attorney? | Yes | No |
| 9. During the current policy period has there been a change in your health? | Yes | No |
| 10. (For policies where named insured is an entity or policies where telemedicine is present) | | |

Please provide the number of annual patients encounters / client visits:

Last 12 months _____ Estimate for next 12 months _____

I HEREBY DECLARE THAT I HAVE READ THE ABOVE RENEWAL APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I FURTHER ACKNOWLEDGE ANY MISREPRESENTATION OR LACK OF NOTIFYING THE CARRIER OF CHANGES IN MY PRACTICE MAY RESULT IN COVERAGE BEING VOIDED.

Primary Insured Signature

Date

Print Name