Applicant's last names: _____

INSURANCE APPLICATION UPDATE FORM

THIS WILL NOT SUBSTITUTE THE ORIGINAL APPLICATION THAT MUST BE SUBMITTED WHEN SOLICITING COVERAGE FOR THE FIRST TIME

Please update the following information previously submitted on your first application for medical malpractice coverage with PRMD (in case of needing any more space please refer to the Remarks Section on page 4):

You are currently insured by PRMD for: ☐ Primary: PP- _____ ☐ Excess: PE- _____

PLEASE SPECIFY THE TYPE OF COVERAGE YOU ARE APPLYING FOR:

____ A. Primary Limits Policy: ☐ $100,000 per medical incident / $300,000 aggregate

____ B. Excess Over Primary Limits Policy

☐ $150,000 per medical incident / $200,000 aggregate ☐ $400,000 per medical incident / $700,000 aggregate
☐ $250,000 per medical incident / $500,000 aggregate ☐ $500,000 per medical incident / $1,000,000 aggregate
☐ $1,000,000 per medical incident / $3,000,000 aggregate

I PERSONAL INFORMATION

1. Name: _____
First Name Middle Name Last Name Second Last Name

Date of Birth (mm/dd/yyyy): _____

Office Address: _____

Postal Address: _____

Office Phone: _____ Cell Phone: _____

Office Fax: _____ E-mail: _____

II PRACTICE PROFILE

2. Check the boxes that best describe the type of practice you currently have:

☐ Solo Physician ☐ Partnership ☐ Professional Association ☐ Other
☐ Employed physician ☐ Group Member ☐ Professional Corporation

3. Primary Specialty: _____ % of Practice _____%

4. Secondary Specialty: _____ % of Practice _____%

5. Do you practice/work shifts in an Emergency Room or a Treatment and Diagnostic Center "CDT"? ☐ Yes ☐ No

6. Do you perform any of the following: drainage of an abscess, tissue biopsies, incising of boils and superficial fascia, suturing or minor lacerations, removal of superficial skin lesions? ☐ Yes ☐ No

7. Do you anticipate your practice will change significantly in the coming year? _____ ☐ Yes ☐ No

8. Have new Hospitals and/or other surgical centers or facilities granted you privileges since your last application:

_____
Hospital/Facility City Privileges Restrictions

9. List any office where you currently practice:

_____
Address/Suite City/State Country

Applicant's last names: _____

10. If in Question #2 you checked any box other than "Solo Physician", list below the name of entity (ies), your position, and names of associates, partners,
shareholders, employees.

_____
Name of Entity (if any) position (partner, shareholder, employee, contractor)

_____
Name of partners, shareholders, employers or associates

III GOVERNMENTAL ACTION

11. Have you ever had any hospital or surgical outpatient privileges denied, suspended, revoked, restricted, reduced, not renewed, proctored or modified in any way? ☐ Yes ☐ No

12. Have you ever been investigated by any entity which its principal activity is a health care service plan? ☐ Yes ☐ No

13. Have you ever been investigated as the subject of, charged with or convicted of a misdemeanor or felony, or entered a "no contest" plea to a crime (for other than a traffic violation)? ☐ Yes ☐ No

14. Have you ever been investigated by any state or federal regulatory or specialty society? ☐ Yes ☐ No

15. Has any governmental agency ever suspended, revoked, restricted, or taken any other action against you/your medical or narcotics license or placed you on probation? ☐ Yes ☐ No

16. Have you EVER been evaluated, recommended for treatment, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction, mental illness? ☐ Yes ☐ No

17. Are you being treated for any medical condition, disease or illness that affects your ability to practice medicine (physical handicap or any chronic illness)? ☐ Yes ☐ No

18. Have you EVER been accused of sexual misconduct of any kind? ☐ Yes ☐ No

IV CLAIMS HISTORY

19. Have you been involved in a malpractice claim or suit, either directly or indirectly since policy coverage by PRMD has been granted? ☐ Yes ☐ No

19a. Did you report the incident to PRMD? ☐ Yes ☐ No

20. Are you aware of any of the following circumstances (not included on previous submissions) that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit:

(a) A request for records from a patient and/or attorney related to an adverse outcome? ☐ Yes ☐ No

(b) A letter from an attorney regarding your medical treatment of a patient? ☐ Yes ☐ No

(c) Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ☐ Yes ☐ No

(d) Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ☐ Yes ☐ No

(e) Any other circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No

(f) If you answer "Yes" to any of the items (a) through (e) above, have these circumstances been reported to your current professional liability carrier? (Please provide evidence.) ☐ Yes ☐ No

Applicant's last names: _____

V REMARKS SECTION

_____

_____

_____

_____

INCIDENT/CLAIMS INFORMATION FORM

*If there are no claims to be reported please mark N/A. **Signature IS required.***

1. Name of Patient _____
2. Date of Incident (mm/dd/yyyy): _____
3. Insurance Carrier: _____ Date reported: _____
4. Allegations: _____
   _____
   _____
5. Present Condition of Patient: _____
6. Signature: _____

VI CONDITIONS OF APPLICATION UPDATE FORM

I hereby declare that the above statements and particulars are true and I agree that this application update form shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including, without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physicians, companies, or professional associations.

I understand that any material misrepresentation or omission made by me on this application update form may act to render any contract of insurance null and without effect or provide the company with the right to rescind it. By presenting this application update form, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

Printed Name: _____Signature: _____Date: _____

AUTHORIZATION TO RELEASE INFORMATION – FOR HOSPITALS/MEDICAL STAFFS/AMBULATORY FACILITIES

As an *applicant for* professional liability insurance coverage from the Company, I hereby give my consent to Puerto Rico Medical Defense Insurance Company, its agents and representatives, to make inquiries to hospitals, medical staffs, ambulatory facilities, health care serve plans or other managed care organizations where I have exercised or applied for clinical privileges or membership. I grant permission to such hospitals, medical staffs and managed care organizations and their representatives and agents to provide information to Puerto Rico Medical Defense Insurance Company which pertains to those privileges I have exercised and to my fitness and qualifications to exercise such privileges. This includes but is not limited to information relating to the scope of privileges granted, any special limitations imposed on such privileges and any information regarding any disciplinary action taken with respect to such privileges. I further agree that the organization releasing the information, its representatives, agents and employees shall not incur any liability as a result of furnishing or releasing information pursuant to this authorization, even if such information is incomplete or incorrect.

_____

Signature Print Name Date

Applicant's last names: _____

AUTHORIZATION TO RELEASE INFORMATION – PROFESSIONAL CREDENTIALS AND QUALIFICATIONS FROM EDUCATIONAL FACILITIES

I hereby grant permission to Puerto Rico Medical Defense Insurance Company to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have been granted privileges or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers. The information requested may include otherwise privileged and confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics or any other matter having bearing on the underwriting procedures. I release and agree to hold harmless Puerto Rico Medical Defense Insurance Company and its representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from the gathering or legal use of such information to evaluate the issuance or renewal of the requested policy.

_____

Signature Print Name Date

AUTHORIZATION TO RELEASE INFORMATION – LOSS HISTORY

I authorize the release to Puerto Rico Medical Defense Insurance Company of information regarding past and pending claims and underwriting matters from my prior professional liability insurance carriers, or from my past and present medical association or society. I further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

_____

Signature Print Name Date

If Certificates of Insurance are required for this coverage, specify to whom (name and address):

_____

_____

Agency: _____

Authorized Representative's Name: _____ Representative's Signature: _____

Cellular No.: _____ E-mail: _____

Postal Address: _____

_____

□ In case of payment being part of the submission please complete the following:

Conditional Receipt

The Authorized Representative signing this document on _____(mm/dd/yyyy) certifies to have received from Dr. _____ authorization to process the payment through check, money order, Credit Card or Bank ACH the total amount of $_____ as payment for the quoted premium. The Medical Malpractice Policy requested will not be effective until the date of approval of the application for insurance. Accepting payment and / or authorization WILL NOT guarantee neither coverage nor policy issuance. If coverage is not approved, the total premium received will be refunded in 30 days or less if solicited, and if not in no more than 90 days as provided in Article 27.160 (3) of the Insurance Code of Puerto Rico. The transaction will be made through _____, General Agency, duly authorized by PRMDIC and responsible for payment to the insurer or for refund of the premium received to its client.

Check # _____ Bank's Name: _____ Account No. : _____

Credit Card # _____ (Please Check: □ Visa □ Master Card □ Discover)

Expiration Date: _____ Security Code: _____

_____ _____

Applicant's Signature Authorized Representative's Signature