



#33 Calle Resolución Suite 702 San Juan, PR 00920 Phone (787)999-7763 Fax (787)993-7763

INVOICE #02 Date:10/22/2020

POLICLINICA LUIS RODRIGUEZ AVE CAMPO RICO A6 CASTELLANAS GARDENS CAROLINA PR 00983 Policy Number: CP-60007

**TOTAL AMOUNT:** \$1,102.00

Invoice	Effective	Description	AMOUNT
02	01/12/2013	Primary Policy:CP-60007 Effective From 01/12/2013 to 01/12/2014	\$1,102.00
		Group Discount: GRUPO CASTELLANO	
		TOTAL	\$1,102.00

Thank you for your business.

Thank you for your business.

#### PUERTO RICO MEDICAL DEFENSE INSURANCE COMPANY

The Corporate Center Building • Suite 702 • Calle Resolución #33 • San Juan, PR 00920-2707

#### Physicians, Surgeons and Dentists Professional Liability Insurance Policy

This Declarations Page is attached to and forms part of the insurance policy.

#### **RENEWAL ENDORSEMENT**

1. **Named Insured**: POLICLINICA LUIS RODRIGUEZ

2. **Named Insured's** Address: AVE CAMPO RICO A6 CASTELLANAS GARDENS CAROLINA PR 00983

3. Producer: RESOLVE GENERAL AGENCY

MUGUET LANDRAU

4. Policy Number: CP-60007

5. **Policy Period** From: 01/12/2013 To: 01/12/2014

Both days at 12.01 A.M. Local Standard Time at the Named Insured's address shown in Item 2.

6. Retroactive Date: 01/12/2012

7. Limits of Liability:

The insurance afforded is only with respect to the following coverages as are indicated by specific premium charge or charges, subject to the Limits of a Liability stated herein and to all the terms of this policy relating thereto. Furthermore, separate policies will be issued for each Coverage A and Coverage B when applied for and both coverages are provided by the **Company**.

a. Coverage A – Individual Coverage

Limits of Liability	N/A	per Medical Incident	N/A	aggregate
Premium	No Coverage			

b. Coverage B – Partnership, Association or Corporation Professional Liability

Limits of Liability	\$100,000	per <b>Medical Incident</b>	\$300,000	aggregate
Premium				\$1,102.00

8. The number of professional **employees** employed by the **Insured** under Coverage B:

Professional Employees	Coverage B
Physicians/ Surgeons / Dentist	3
Allied Healthcare Providers	1

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- 9. Additional locations under Coverage B:
- 10. The **Named Insured** is engaged in the practice of Family or General Practice- MS; Class Code: 80421 and is dully registered and licensed to practice this profession under the laws of the Commonwealth of Puerto Rico.
- 11. Puerto Rico Physician, Surgeon or Dentist License Number: N/A.
- 12. The **Named Insured**:
  - a. is not connected with any partnership other than that described in item (8);
  - b. is not an owner or operator of a hospital, sanatorium or clinic with bed and board facilities;
  - c. does not perform major surgery;
  - d. does not perform minor surgery;
  - e. does not use X-Ray apparatus for therapeutic treatment;
  - f. has no other professional specialty;

Please list any exceptions to a., b; c; d; e; or f.: d.

- 13. Forms and endorsements forming part of this policy at time of issue:
  - a. Form SED: Schedule of Endorsement
  - b. Form P-102: Mandatory Premium and Coverage Conditions Endorsement Puerto Rico
  - c. Form P-103: Continuous Renewal Endorsement

			Lunge Comme Com
Countersigned on	10/22/2020	in San Juan, PR, by:	
C		, , , _	Authorized Representative

## PUERTO RICO MEDICAL DEFENSE INSURANCE COMPANY 33 Calle Resolución • Suite 702 • San Juan, PR 00920-2707

### WASTE means any waste material:

a. containing by-product material; and

b. resulting from the operation by any person or organization of any nuclear facility included within the definition of nuclear facility under paragraph a. or b.

President Treasurer

Puerto Rico Medical Defense Insurance Company Puerto Rico Medical Defense Insurance Company

Countersigned by:

Lucyll Correa Nieves 10/22/2020

Name Signature Date



PHYSICIANS, SURGEONS, DENTISTS, AND ALLIED HEALTHCARE PROVIDERS PRIMARY AND/OR EXCESS PROFESSIONAL LIABILITY Page 1 of 4

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\*\*

		on previously submitted on the Rem		for medical malpractice	coverage with
You are currently i	nsured by PRMD for:	□ Primary: PP	□ Excess: PE-		
PLEASE SPECIF	Y THE TYPE OF COV	ERAGE YOU ARE APPLY	ING FOR:		
A.	Primary Limits Policy	y: □ \$100,000 per medical	incident / \$300,000 aggre	egate	
B.	Excess Over Primary	y Limits Policy			
	□ \$250,000 per me	dical incident / \$200,000 ag dical incident / \$500,000 ag edical incident / \$3,000,000	gregate □ \$500,000 pe		
I <u>PERSONAL INFO</u>	<u>RMATION</u>				
Date of Birth (mm/do Office Address:	First Name d/yyyy):	Middle Name	Last Name	Second Last Nan	ne
Postal Address: Office Phone:					
Office Fax:			E "		
II PRACTICE PROF	<u>ILE</u>				
2. Check the boxes  ☐ Solo Physic  ☐ Employed p	cian $\square$	•		Other	
3. Primary Specialty	<i></i>			% of Practice	%
4. Secondary Specia	alty:			% of Practice	%
5. Do you practice/v	vork shifts in an Emerger	ncy Room or a Treatment and	Diagnostic Center "CDT"?		□ Yes □ No
	ny of the following: drain	age of an abscess, tissue biop	osies, incising of boils and su	uperficial fascia, suturing or mi	inor lacerations, ☐ Yes ☐ No
7. Do you anticipate	your practice will chang	e significantly in the coming ye	ear?	<del></del>	☐ Yes ☐ No
8. Have new Hospita	als and/or other surgical	centers or facilities granted you	ı privileges since your last a	pplication:	
Hospital/Facilit	у (	City	Privileges	Restrictions	
9. List any office wh	ere you currently practic	e:			
Address/Suite		City/State		Country	



# PHYSICIANS, SURGEONS, DENTISTS, AND ALLIED HEALTHCARE PROVIDERS PRIMARY AND/OR EXCESS PROFESSIONAL LIABILITY Page 2 of 4 $\,$

Applicant's last names:

par	I. If in Question #2 you checked any box other than "Solo Physician", list below the name of entity (inthers, shareholders, employees.	es), your position, and names of associates	i.
	Name of Entity (if any) position (partn	er, shareholder, employee, contractor)	
	Name of partners, shareholders, employers or associates		
Ш	GOVERNMENTAL ACTION		
11.	. Have you ever had any hospital or surgical outpatient privileges denied, suspended, revoked, remodified in any way?	·	r No
12.	. Have you ever been investigated by any entity which its principal activity is a health care service	plan?	s 🗆 No
13.	. Have you ever been investigated as the subject of, charged with or convicted of a misdemeanor of	or felony, or entered a "no contest" plea to a	a crime
	(for other than a traffic violation)?	☐ Yes	s □ No
14.	. Have you ever been investigated by any state or federal regulatory or specialty society?	☐ Yes	s □ No
15.	. Has any governmental agency ever suspended, revoked, restricted, or taken any other action aga you on probation?	, ,	or placed S □ No
16.	Have you EVER been evaluated, recommended for treatment, diagnosed with, or treated for alco sexual addiction, mental illness?	·	e, S 🗆 No
17.	. Are you being treated for any medical condition, disease or illness that affects your ability to practillness)?		onic s 🗆 No
18.	Have you EVER been accused of sexual misconduct of any kind?	□ Ye	s □ No
IV	<u>CLAIMS HISTORY</u>		
19.	. Have you been involved in a malpractice claim or suit, either directly or indirectly since po	licy coverage by PRMD has been grante	<b>d</b> ?
		□ Yes	s □ No
	19a. Did you report the incident to PRMD?	□ Yes	s □ No
20.	. Are you aware of any of the following circumstances (not included on previous submissio being brought against you, even if you believe the claim or suit would be without merit:	ns) that might reasonably lead to a claim	ı or suit
(a)	A request for records from a patient and/or attorney related to an adverse outcome?	□Yes	s □ No
(b)	A letter from an attorney regarding your medical treatment of a patient?	□ Yes	S □ No
(c)	Intra-operative or post-operative complications or other complications resulting in death, paralysis	, or other significant disabilities? $\ \square$ Yes	s □ No
(d)	Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis	? \( \sum \text{Ye}	s □ No
	Any other circumstances that might reasonably lead to a claim or suit?  If you answer "Yes" to any of the items (a) through (e) above, have these circumstances be		s □ No I
lial	bility carrier? (Please provide evidence.)	□ Yes	s □ No



## PHYSICIANS, SURGEONS, DENTISTS, AND ALLIED HEALTHCARE PROVIDERS PRIMARY AND/OR EXCESS PROFESSIONAL LIABILITY

Page 3 of 4

	Applicant	t's last names:	
ense Insuran	c e		
V REMARKS SECTION			
	INCIDENT/CLAIMS INF		
	If there are no claims to be reported pleas	e mark N/A. Signature IS required.	
1. Name of Patient			
2. Date of Incident (mm/dd/yyyy	y):		
3. Insurance Carrier:		Date reported:	
4. Allegations:			
	:		
6. Signature:			
VI <u>CONDITIONS OF APPLICAT</u>	ION UPDATE FORM		
Company. I agree to notify the (	statements and particulars are true and I agree Company if there is any future material change iation, or working arrangement with any other p	in any answer to this application, inclu	iding, without limitation, any change
null and without effect or provide	nisrepresentation or omission made by me on e the company with the right to rescind it. By p age has or will be extended to me or that a polic	presenting this application update form	
I further understand and agree offered me a premium quote; and	that I have no right to demand or expect cove d (3) received, as a precondition to coverage, the	rage until the Company has: (1) rece ne total premium due.	eived my completed application; (2)
I agree that if I fail to compl applying.	ly with these terms I will have no covera	ge for any claim under any poli	cy of insurance for which I am
Printed Name:	Signature:	Da	te:
AUTHORIZATION TO RELEAS.	E INFORMATION – FOR HOSPITALS/MEDICA	AL STAFFS/AMBULATORY FACILIT	ΓΙES
Company, its agents and repres care organizations where I have managed care organizations an pertains to those privileges I hav relating to the scope of privileges with respect to such privileges. I	I liability insurance coverage from the Companientatives, to make inquiries to hospitals, medicine exercised or applied for clinical privileges of their representatives and agents to provide the exercised and to my fitness and qualifications is granted, any special limitations imposed on suffurther agree that the organization releasing thing or releasing information pursuant to this authorized.	al staffs, ambulatory facilities, health r membership. I grant permission to information to Puerto Rico Medical E to exercise such privileges. This inclused privileges and any information regulation, its representatives, ag	care serve plans or other managed such hospitals, medical staffs and Defense Insurance Company which udes but is not limited to information parding any disciplinary action taken lents and employees shall not incur
Signature	Print Na	me	 Date
- 9	, inche	-	



### PHYSICIANS, SURGEONS, DENTISTS, AND ALLIED HEALTHCARE PROVIDERS PRIMARY AND/OR EXCESS PROFESSIONAL LIABILITY

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 Date Print Name If Certificates of Insurance are required for this coverage, specify to whom (name and address): Authorized Representative's Name: \_\_\_\_\_ \_\_\_\_\_ Representative's Signature: \_\_\_\_\_ \_\_\_\_\_\_ E-mail: \_\_\_\_\_ Postal Address: □ In case of payment being part of the submission please complete the following: **Conditional Receipt** \_\_\_(mm/dd/yyyy) certifies to have received from The Authorized Representative signing this document on \_\_\_\_\_ 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. Bank's Name: \_\_\_\_\_\_ Account No. : \_\_\_\_\_ \_\_\_\_\_ (Please Check: 

Visa 

Master Card 

Discover) Expiration Date: \_\_\_\_\_\_ Security Code: \_\_\_\_\_

Authorized Representative's Signature

Applicant's Signature



#### PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY INSURANCE POLICY

Certificate Number: 132885 Date: 10/22/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER, THIS CERTICATE DOES NOT AFFIRMATELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW, THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER AND THE CERTIFICATE HOLDER.

**RESOLVE GENERAL AGENCY** Insured: POLICLINICA LUIS RODRIGUEZ Agency: Producer: MUGUET LANDRAU Specialty: /Family or General Practice- MS / Cancelation: (Class Code: 80421) SHOULD THE ABOVE DESCRIBED POLICY BE CANCELLED BEFORE Vicariously Insured Physician(s): 3, Other Personel: 1 THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

THIS IS TO CERTIFY THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INNSURACE NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOT WITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDICIONS OF SUCH POLICIES, LIMITS SHOWN MAY HAVE BEEN REDUCE BY PAID CLAIMS.

1	TYPE OF INSURANCE	POLICY NUMBER	RETROACTIVE DATE	POLICY EFF. (MM/DD/YYYY)	POLICY EXP. (MM/DD/YYYY)	LIMIT	
P	rofessional Liability Claims Made	CP-60007	01/12/2012	01/12/2013	01/12/2014	Each Medical Claim	<u>\$100,000.00</u> <u>\$</u> n/a
						Aggregate	\$300,000.00 \$ n/a

Retroactive coverage for this policy has been interrupted and no coverage will be affored on claims ocurring during the following period(s):

Certificate Holder's Name: Certificate Holder's Address:

PO Box 13969 Junta de Licenciamiento Y Disciplina Médica

San Juan PR 00908.

PUERTO RICO MEDICAL DEFENSE INSURANCE COMPANY

**Authorized Representative**